PATIENTS INITIALS:_____ ID: _____

Western North Carolina Community Health Services

PATIENT REGISTRATION FORM

Please return completed forms to the front desk

*INDICATES A REQUIRED FIELD

PATIENT INFORMATION

*Patient's First Name | *Patient's Last Name | Middle Initial | Preferred name | *Date of Birth (mm/dd/yy)

Email address | Home phone # | Mobile phone #

*Mailing address | Apartment | Street address | Apartment

*City | *State | *ZIP Code | City | State | ZIP Code

*Preferred method of contact? Home Phone ( ) Mobile Phone Email ( ) Text ( )

**By checking above you are consenting to receive healthcare communications from WNCCHS, unless you decline healthcare communication in writing.

*Have you previously been a patient here? NO ( ) YES ( )

Marital status (select one)? Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( )

*How did you hear about us? Family / Friend ( ) DSS ( ) Health Dept. ( ) Private Physician ( ) Internet / Online ( ) Former Patient ( )

*What is your race? Asian ( ) American Indian / Alaskan Native ( ) Black / African American ( ) White ( ) Native Hawaiian ( ) Other Pacific Islander ( ) Choose not to disclose ( )

*What is your ethnicity? Latino / Hispanic ( ) Non-Latino / Hispanic ( ) Not Reported ( )

Employment Status? Employed ( ) Unemployed ( ) Student ( ) Disabled ( ) Retired ( )

Sex on birth certificate? Male ( ) Female ( )

Gender Identity? Male ( ) Female ( ) Transgender (Female to Male) ( ) Transgender (Male to Female) ( ) Genderqueer ( ) Choose not to disclose ( )

Sexual Orientation? Straight ( ) Gay ( ) Lesbian ( ) Bisexual ( ) Unknown ( ) Choose not to disclose ( )

Pharmacy Name: _____ Location: _____

Do you have a healthcare power of attorney (POA)? YES ( ) NO ( ) If yes, please provide a copy

IN CASE OF EMERGENCY

Emergency contact Name | Relationship to patient | Phone No. | Alternate Phone No.

*Information to release to contact? Complete Medial Records ( ) Appointment ( ) Financial / Billing ( ) Pharmacy Pick-Up ( ) Emergency Information ( ) Lab Results ( ) Examination ( ) Diagnosis ( ) My Treatment Other specific purpose ( ) _____

ACKNOWLEDGEMENT OF HEALTH INFORMATION EXCHANGE

The North Carolina Information Exchange (HIE) is a way of sharing patient health information among participating doctor's offices, hospitals, labs, radiology centers, and other health care providers. The purpose is to ensure that each caregiver has the most recent information available from other providers. WNCCHS has decided to participate in the most recent NCHIE as a means of sharing our patient data among other health care providers in the state of North Carolina and may participate in other exchanges as they become available. If you do not wish your information to be viewed by other providers, there are opt-out forms on the NCHIE's website that you may send directly to the NCHIE (www.hiea.nc.gov)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ , hereby acknowledge receipt of the Notice of Privacy Practices given to me by Western North Carolina Community Health Services.

By signing, I confirm all of my information provided is correct. Patient Signature (or Guardian): _____ Date: _____

Staff Initials: _____

Western North Carolina Community Health Services

PATIENT REGISTRATION FORM

RESPONSIBLE PARTY

(Please complete for all patients under 18 years old)

Last Name, First Name	Relationship to patient	Social Security No.	Date of Birth

PRIMARY INSURANCE

Plan Name: _____ ID Number: _____

Policy Holder: _____ Group Number: _____

Policy Holder DOB: _____

SECONDARY INSURANCE

Plan Name: _____ ID Number: _____

Policy Holder: _____ Group Number: _____

Policy Holder DOB: _____

NO SHOW ~ LATE ~ AND CANCELLATION POLICY

Any visit that the patient does not call and cancel/reschedule 24 hours prior to the appointment or the patient does not attend within a ten-minute grace period following the appointment time, the visit is considered a "No Show" appointment. If you have continued No Show appointments, you could be restricted for scheduling of future appointments. Please be considerate of your medical providers time and call **828-285-0622,** in advance to let WNC-CHS know if you cannot attend your scheduled visit.

FINANCIAL INFORMATION

Please be advised that your insurance may not cover all your charges and you are responsible for any balance on your account and will be billed until that balance is paid in full. WNCCHS requires payment on the day of service. This payment includes outstanding deductibles, co-payments, non-covered services or sliding fee payments on any remaining charges after insurance has made payment on your account. As a patient of WNCCHS, you may be eligible for discounted services. Our services are available on an "ability to pay" basis, we simply ask that you request a sliding fee scale application and provide accurate information for a review of eligibility. WNCCHS considers your household income and family size and charge a nominal fee based on information provided. If your health care benefits do not cover clinical laboratory testing services, you will receive a separate bill from Lab Corp that you will be responsible for, if specimen collection services are performed.

Thank you for choosing us as your healthcare partner. Signing of this form indicates you are aware of the above and were advised of the sliding fee program. I hereby authorize assignment of all insurance benefits payable directly to WNCCHS.

Patient Signature (or Guardian): _____ **Date:** _____

Staff Initials: _____

Western North Carolina Community Health Services FQHC

CONSENT FOR EVALUATION AND TREATMENT

Western North Carolina Community Health Services, Inc. (WNCCHS) is dedicated to providing quality primary care services to the community. Primary Care includes preventive, urgent, and chronic disease care for medical and behavioral health conditions/problems. This also includes laboratory tests (including HIV and urine drug screens), other diagnostic tests. I understand that I can decline HIV screening and other diagnostic testing.

Comprehensive and coordinated care may require your providers to involve other healthcare specialists as part of your care team. Members of your health care team will collaborate and share clinical information. Documentation by all care team providers, including behavioral health, will be stored in our electronic medical record.

I understand if I am 18 years of age or older, I may consent for all health services; otherwise my parent or legal guardian will need to consent to services. Be aware that, NC state law does allow those that are not yet 18 to consent to treatment without parental consent or notification when such treatment is related to sexual health, pregnancy, substance use and/or abuse, or mental health services. Please consult with your treatment provider if you are interested in providing your own consent.

Purpose of Document: The purpose of this document is to outline your rights and responsibilities as a patient of WNCCHS, as well as our rights and responsibilities to you. Please review this document very carefully and feel free to ask any questions or seek clarification from your WNCCHS provider about items contained within this document. Please sign this form to signify that you have read it in its entirety. You will receive a copy of this signed consent form.

Limits of Confidentiality: All information that you disclose to your WNCCHS provider during the course of treatment is confidential and will not be revealed without your written permission (or your parents' permission if you are under 18 years old) except for treatment, payment, or healthcare operations as permitted by law. Disclosure, may also be permitted or required by law when: (1) there is reasonable suspicion of child abuse, elder adult abuse and/or abuse of disabled adults; (2) there is a reasonable suspicion that you may present a danger of violence to others; and/or (3) there is a reasonable suspicion that you are likely to harm yourself. Disclosure may be required pursuant to a legal proceeding. If you have any questions about the limits of confidentiality, please discuss these concerns with behavioral health provider prior to signing this document.

HIPAA: The HIPAA Privacy Rule, a regulation developed by the U.S. Department of Health and Human Services, establishes a minimum level of privacy protection for health care information. The Privacy Rule establishes a patient's rights regarding the use and disclosure of his/her health care information. Please be aware that we will send information as requested by your insurance company in order to obtain payment. Your signature below indicates that you authorize WNCCHS to file for payment with your insurance company. Our Notice of Privacy Practices is available on our website (www.WNCCHS.org) or upon request.

By signing this form (parent or legal guardian signature, if required), I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered.

I hereby agree and consent to evaluation and treatment for myself and/or child(ren) as set forth above, including any studies or procedures that WNCCHS professional staff decide are necessary or appropriate. I may revoke my consent at a later time. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Patient Signature (or Guardian): _____ **Date:** _____

Staff Initials: _____

Western North Carolina Community Health Services FQHC

PATIENT AGREEMENT

The patient named above agrees to ALL the terms and conditions listed below. My signature below certifies that I read (or someone read to me) this entire document, that I understand it, and that I have the legal authority to sign for the patient named above.

- To tell us the patient's health history, including all health care providers (e.g., specialists) serving the patient AND all medications/drugs (prescribed and unprescribed) the patient is taking.
- If something we tell the patient is not clearly understood by the patient or his/her legal guardian/ representative, to ask us to clarify until it is clearly understood.
- To keep every scheduled appointment or reschedule before the appointment. A patient who has not come to the clinic in 12 months is deactivated. This means we cannot serve the patient again until he or she completes the new patient enrollment process (Intake).
- To follow, to the best of the patient's ability, the agreed upon health care plan, or express concerns if unable to follow it.

To refrain from engaging in any of the prohibited behaviors listed below:

- Possessing a weapon or firearm of any kind with or without a license/permit while on WNCCHS leased or owned property.
- Using, or attempting to use, physical force or violence against any individual—regardless of the means, e.g., hands or fists, legs, use of any object as a weapon.
- Communicating any threats, explicit or implied, verbally or in writing, of any physical/psychological/emotional harm to any individual at or connected with WNCCHS—even if the threat is expressed only through electronic means (e.g., social media).
- Disregarding any policy, procedure, request, or instruction that authorized WNCCHS personnel deem necessary and appropriate to maintain safety, orderly operations, and a respectful environment.
- Directing any obscene, foul, vulgar, or offensive language to any individual at WNCCHS.
- Making degrading comments about anybody's race, religion, ethnicity, national origin, sex, sexual orientation, gender identity, disability, diagnoses, immigration status, English proficiency, literacy/educational level, or physical appearance (e.g., "body shaming). WNCCHS considers all such comments to be hate speech and will not be tolerated.
- Invading or violating the privacy and confidentiality of any individual at WNCCHS by recording, reproducing, or disseminating the individual's image, voice, or identifying information (e.g., "tagging" and posting on Facebook) without the individual's explicit written consent.
- *Physical destruction of WNCCHS property or property of an employee, patient or member of the public.*

Patient Name (Printed): _____

Patient Signature (or Guardian): _____ Date: _____

Staff Initials: _____