Community Health Programs
Patient Registration

Last Name: ____
First Name: ____
Preferred name:____
Middle Initial: ___________ Suffix: _______________ Gender: Male Female
Former Last Name: ____
Date of Birth: _____/_____/_____ Social Security Number: ______________________________
SSN: ____
Mailing Address: ____
Physical Address: ____
Zip Code: ____________________ City: __________________________ State: ______________
Home Phone (___)_____________ Work Phone (___)_____________ Cell Phone (___)____________
Patient email:____

MARITAL STATUS: Married Single Divorced Widowed Domestic Partners

LANGUAGE: English Other: ____________________ (specify)

RACE: Asian More Than One Race White
Hispanic or Latino/Spanish African American/Black American Indian/Alaska Native
Other: (please specify) ______________________

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

Primary Care Provider: ___________________________________

Native Hawaiian: Yes No

INCOME: **See attached sheet (page 2) for Income guidelines**
** Required by Department of Public Health and Human Services**

PLEASE CHECK THE APPROPRIATE BOX FOR INCOME LEVEL

100% and below:______________ 151%-200%:______________
101%-150%:__________________ Over 200%:_______________
Income unknown:_____________

Living Status/Homeless Status
Not homeless Doubling up Homeless Shelter Street Transitional Other Unknown

Migrant Status: Yes No Public Housing Yes No Veteran Status: Yes No

How did you hear about us?
Advertising Patient in Practice
Primary Care Hospital
Specialist Physician Insurance company
Word of Mouth Other: ___________________________________

Would you like to receive CHP mailings, newsletters, or announcements about our practice or services? Yes No

Are you or your family members WIC participants Y or N

2015 Federal HHS Poverty Guidelines

Weekly Income: # in Family	100 % and Below	101%-150%	151%-200%	Over 200%
1	$ 226.35	$ 339.54	$ 452.71	$ 679.06
2	$ 306.35	$ 459.54	$ 612.69	$ 919.04
3	$ 386.35	$ 579.54	$ 772.69	$ 1,159.04
4	$ 466.35	$ 699.54	$ 932.69	$ 1,399.04
5	$ 546.35	$ 819.54	$ 1,092.69	$ 1,639.04
6	$ 626.35	$ 939.54	$ 1,252.69	$ 1,879.04
7	$ 706.35	$ 1,059.54	$ 1,412.69	$ 2,119.04
8	$ 786.35	$ 1,179.54	$ 1,572.69	$ 2,359.04
for each additional person, add	$ 80.00	$ 120.00	$ 160.00	$ 240.00

Monthly Income: # in Family	100% and Below	101%-150%	151%-200%	Over 200%
1	$ 980.83	$ 1,471.33	$ 1,961.75	$ 2,942.58
2	$ 1,327.50	$ 1,991.33	$ 2,655.00	$ 3,982.50
3	$ 1,674.17	$ 2,511.33	$ 3,348.33	$ 5,022.50
4	$ 2,020.83	$ 3,031.33	$ 4,041.67	$ 6,062.50
5	$ 2,367.50	$ 3,551.33	$ 4,735.00	$ 7,102.50
6	$ 2,714.17	$ 4,071.33	$ 5,428.33	$ 8,142.50
7	$ 3,060.83	$ 4,591.33	$ 6,121.67	$ 9,182.50
8	$ 3,407.50	$ 5,111.33	$ 6,815.00	$ 10,222.50
for each additional person, add	$ 346.67	$ 520.00	$ 693.33	$ 1,040.00

Annual Income: # in Family	100% and Below	101%-150%	151%-200%	Over 200%
1	$ 11,770.00	$17,656.00	$ 23,541.00	$ 35,311.00
2	$ 15,930.00	$23,896.00	$ 31,860.00	$ 47,790.00
3	$ 20,090.00	$30,136.00	$ 40,180.00	$ 60,270.00
4	$ 24,250.00	$36,376.00	$ 48,500.00	$ 72,750.00
5	$ 28,410.00	$42,616.00	$ 56,820.00	$ 85,230.00
6	$ 32,570.00	$48,856.00	$ 65,140.00	$ 97,710.00
7	$ 36,730.00	$55,096.00	$ 73,460.00	$110,190.00
8	$ 40,890.00	$61,336.00	$ 81,780.00	$122,670.00
for each additional person, add	$ 4,160.00	$ 6,240.00	$ 8,320.00	$ 12,480.00

CONTACT INFORMATION

Guardian Last Name (if applicable): ____
Guardian First Name (if applicable): ____

Emergency Contact Name: ____
Emergency Contact Relation: ____
Emergency Contact Phone: (______)___________ Mobile Phone: (______)______________

Employer Name: ____
Employer Phone: (_____)_____________________ Occupation: _____________________________________

INSURANCE INFORMATION

This Information is vital to properly bill your visits
PAYMENT IS DUE AT TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE

Policy Holder Information: (person who carries or holds the insurance). Self Other

Last Name: ____________________________________ ____
First Name: ____ Middle Initial: _________________________
Mailing Address: ____
Address continued: ____
Zip Code: ___________________________ City: ______________________________________ State: _______________
Date of Birth: ___/___/____ Social Security Number: ______/_______/_______ Male Female
Employer Name: ____

<u>REQUIRED</u> - Guarantor Name: ____
This is the person who is responsible for paying bills not covered by insurance (may not be the policy holder)

Please give the front desk your insurance card so that we can have a copy in the file. Please complete the insurance information below completely to ensure billing accuracy. If you have more than 2 insurances please notify the front desk staff.

1st Insurance		2nd Insurance	
Company Name		Company Name	
Policy Number		Policy Number	
Group Number		Group Number	
Effective Date		Effective Date	
Co-Payment Amount		Co-payment Amount	
Type of Insurance Plan		Type of Insurance Plan	

COMMUNICATION

We are now using an **automated reminder call and messaging system** to notify you of upcoming appointments, lab(s), test results, announcements and billing information. For your upcoming appointments you will be contacted three business days in advance and given the opportunity to confirm or change your appointment. For lab and test results you will be directed to select to hear your results on the phone or view them on the patient portal. Because of this, we need you to answer a few questions so we can set up the call and messaging system to your preferences.

*Text – If you want to receive text messages you must be registered for the Patient Portal
* Portal – Misuse of the portal may result in restriction at any time.

Appointments	Email	Phone	Text
Lab & Test Results	Email	Phone	Text
Billing	Email	Phone	Text
Announcements	Email	Phone	Text
CHP Mailings & Marketing	Email	Phone	Text

** As a non-profit organization, we may also contact you as part of a fund-raising effort, but will not share your personal information with outside organizations for that purpose.*

Please provide us with the following information for our automated messaging system

Email Address: ____
Home/Work Telephone: ____
Mobile Telephone: ____

May we leave a message on your answering machine? Yes or No

Would you like to register for the Patient Portal? Yes or No

We also need to know if there are any restrictions as to who is allowed to reschedule your appointments. Please note these below:
____
____

Please note: if you wish to change any of this information in the future you will have to notify us.

SIGNATURES

Involvement of Care

I hereby request the following person(s) be allowed to participate in my care or payment decision process. I understand that these person(s) may be given health or payment information about me if I am unavailable or unable to communicate. CHP will act on this information until I revoke or amend this authorization in writing.

In the event the person listed below is involved in healthcare decisions for this patient, a healthcare proxy must be completed

Name	Relationship	Phone #	Information Released

Do not disclose any information to any person

Authorization to Treat

I do hereby authorize the rendering of such care, which may include routine diagnostic procedures and such medical treatment as deemed necessary by the physician or provider in charge of my care. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this facility.

Signature: ____ Date: __________________________________
If legal representative, relationship to patient: ____

Privacy Practices/Patient Responsibilities
My signature below indicates that I have been provided with a copy of the notice of privacy practices and patient responsibilities.

Signature: ____ Date: __________________________________
If legal representative, relationship to patient: ____

Financial Consent

This is a "lifetime" financial consent concerning outpatient services records which shall continue in effect unless and until I revoke it by written request. I authorize payment directly to CHP and any benefits payable under the terms of my insurance/third party payer. I understand I am financially responsible for an charges or remaining balances not covered by my insurance/third party payer. I authorize CHP to release all pertinent medical information for purposes of obtaining payment for services rendered, reviewing, or evaluating patient care and/or preparing continuing care.

Signature: ____ Date: _________________________________
If legal representative, relationship to patient: ____

Verified Information and made necessary changes to EMR

Date:	Date:	Date:	Date:	Date:
Initials:	Initials:	Initials:	Initials:	Initials: