



*Thank you!*

Welcome to CHEMED!  
Please complete and return to registrar

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<i>Patient Last Name</i>	<i>(Maiden Name)</i>	<i>Patient First Name</i>	<i>Middle Name</i>

<b>Home Address:</b>					
	<i>Street, Apt#</i>	<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>

<b>Home Phone #:</b> (    )	<b>Work Phone #:</b> (    )	<b>Cell Phone #:</b> (    )
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<b>Date of Birth:</b> /    /	<b>Social Security #:</b> -    -
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<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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Do you have Advance Directives/Living Will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you have any of the following cultural/linguistic barriers to care?	<input type="checkbox"/> Poor Vision <input type="checkbox"/> Poor Hearing <input type="checkbox"/> Language Barrier <input type="checkbox"/> Religious/Cultural barriers <input type="checkbox"/> None of the above
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**Responsible party information (if different than above)**

<b>Name:</b>	<b>D.O.B.</b>	<b>Phone #:</b>
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<b>Pharmacy Name:</b>	<b>Pharmacy #:</b>
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**Emergency contact information:**

<b>Name of person to contact in case of emergency:</b>
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<b>Phone #:</b>	<b>Relationship to Patient:</b> <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other
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Primary Insurance Information	Secondary Insurance Information (if applicable)
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<b>Insurance Company Name:</b>	<b>Insurance Company Name:</b>
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<b>Name of Policy Holder as listed on card:</b>	<b>Name of Policy Holder as listed on card:</b>
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<b>Policy Holder Date of Birth:</b> /    /	<b>Policy Holder Date of Birth:</b> /    /
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<b>Relationship to policy holder:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<b>Relationship to policy holder:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
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<b>Policy ID#:</b>	<b>Policy ID#:</b>
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<b>Insurance Group #:</b>	<b>Insurance Group #:</b>
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**A COPY OF YOUR INSURANCE CARD(S) AND PERSONAL ID IS REQUIRED**

Please be aware that you have the right to request to have a chaperone present in the exam room during any personal examination and to decline the examination if an acceptable chaperone is not present. If you would like to request a chaperone please let the Doctor or Nurse know.	<i>Please initial</i>
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**AGREEMENT**

*In consideration of the examination to be provided by Center for Health Education, Medicine and Dentistry - CHEMED: I understand that the doctor makes no representations about my condition other than those concerning the problem for which he has been retained. Patients have the right to formulate an advance directive. I hereby authorize CHEMED to furnish information to insurance carriers regarding illness and treatments to me and/or my dependants in writing, by e-mail, fax, or through electronic assignment to the appropriate parties as needed. I authorize release of all information necessary to secure payment. I hereby assign to CHEMED any/all benefits/payments received from my insurer, including any personal injury protection coverage, received as a result of a liability settlement. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment and of this signature is to be considered valid. I agree to pay any deductible or other balance not paid by my insurer.*

*I am responsible for payment in full for all fees regardless of insurance reimbursement. Payment is required after each visit for medical services unless other payment arrangements are made. It is our policy that patients who are younger than 18 years of age should be accompanied by their parent/guardian.*

Signature of patient (parent/guardian if minor)	Date	Signature of witness	Date
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Name: \_\_\_\_\_  
 Last, First

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

As a Community Health Center, we are required to report annually to the Federal Government Health Resources and Services Administration (HRSA) on our patient statistics. Please fill out the form below and return to front desk.

YOUR ASSISTANCE WITH THIS SECTION WILL ENABLE AND ENHANCE OUR ABILITY TO SERVE YOU AND THE ENTIRE COMMUNITY

<b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Veteran
<b>Race:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> White
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Other

**PLEASE CHECK-OFF YOUR APPROPRIATE FAMILY INCOME BRACKET**

Family Size	Annual Income Thresholds										
	below	\$10,830	<input type="checkbox"/>	\$10,831 - \$16,245	<input type="checkbox"/>	\$16,246 - \$21,660	<input type="checkbox"/>	\$21,661 or more	<input type="checkbox"/>		
1	below	\$10,830	<input type="checkbox"/>	\$10,831 - \$16,245	<input type="checkbox"/>	\$16,246 - \$21,660	<input type="checkbox"/>	\$21,661 or more	<input type="checkbox"/>		
2	below	\$14,570	<input type="checkbox"/>	\$14,571 - \$21,855	<input type="checkbox"/>	\$21,856 - \$29,140	<input type="checkbox"/>	\$29,141 or more	<input type="checkbox"/>		
3	below	\$18,310	<input type="checkbox"/>	\$18,311 - \$27,465	<input type="checkbox"/>	\$27,466 - \$36,620	<input type="checkbox"/>	\$36,621 or more	<input type="checkbox"/>		
4	below	\$22,050	<input type="checkbox"/>	\$22,051 - \$33,075	<input type="checkbox"/>	\$33,076 - \$44,100	<input type="checkbox"/>	\$44,101 or more	<input type="checkbox"/>		
5	below	\$25,790	<input type="checkbox"/>	\$25,791 - \$38,685	<input type="checkbox"/>	\$38,686 - \$51,580	<input type="checkbox"/>	\$51,581 or more	<input type="checkbox"/>		
6	below	\$29,530	<input type="checkbox"/>	\$29,531 - \$44,295	<input type="checkbox"/>	\$44,296 - \$59,060	<input type="checkbox"/>	\$59,061 or more	<input type="checkbox"/>		
7	below	\$33,270	<input type="checkbox"/>	\$33,271 - \$49,905	<input type="checkbox"/>	\$49,906 - \$66,540	<input type="checkbox"/>	\$66,541 or more	<input type="checkbox"/>		
8	below	\$37,010	<input type="checkbox"/>	\$37,011 - \$55,515	<input type="checkbox"/>	\$55,516 - \$74,020	<input type="checkbox"/>	\$74,021 or more	<input type="checkbox"/>		
9	below	\$40,750	<input type="checkbox"/>	\$40,751 - \$61,125	<input type="checkbox"/>	\$61,126 - \$81,500	<input type="checkbox"/>	\$81,501 or more	<input type="checkbox"/>		
10	below	\$44,490	<input type="checkbox"/>	\$44,491 - \$66,735	<input type="checkbox"/>	\$66,736 - \$88,980	<input type="checkbox"/>	\$88,981 or more	<input type="checkbox"/>		
11	below	\$48,230	<input type="checkbox"/>	\$48,231 - \$72,345	<input type="checkbox"/>	\$72,346 - \$96,460	<input type="checkbox"/>	\$96,461 or more	<input type="checkbox"/>		
12	below	\$51,970	<input type="checkbox"/>	\$51,971 - \$77,955	<input type="checkbox"/>	\$77,956 - \$103,940	<input type="checkbox"/>	\$103,941 or more	<input type="checkbox"/>		
13	below	\$55,710	<input type="checkbox"/>	\$55,711 - \$83,565	<input type="checkbox"/>	\$83,566 - \$111,420	<input type="checkbox"/>	\$111,421 or more	<input type="checkbox"/>		
14	below	\$59,450	<input type="checkbox"/>	\$59,451 - \$89,175	<input type="checkbox"/>	\$89,176 - \$118,900	<input type="checkbox"/>	\$118,901 or more	<input type="checkbox"/>		

Your privacy is very important to us. All information is confidential and will be used **only** for aggregated statistical reports required by HRSA. No personally identifiable information will be disclosed to any party.

*Thank you!*



## HIPAA (Health Insurance Portability & Accountability Act) COMPLIANT POLICY

The HIPAA privacy policy gives you the patient, the right to request a restriction on the uses and releases of your protected health information.

I may be contacted in the following manner (please check all options that apply):

- Home Phone:
- Cell Phone :
- Written Communication:

The HIPAA Privacy Policy gives you, the patient the right to designate a person(s) to act on your behalf.

I designate the following person(s) to act on my behalf. Such action may include, and is not limited to; the discussion of my medical records and surgical care, treatments, prescription requests, documentation of medical records and financial obligations.

Full Name of Designee	Relation to Patient

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Center for Health Education, Medicine and Dentistry - CHEMED. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice in our center. If you have any questions about our *Notice of Privacy Practices*, please ask your CHEMED representative.

I acknowledge receipt of the *Notice of Privacy Practices* of Center for Health Education, Medicine and Dentistry - CHEMED.

Patients signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Print your name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**--- OFFICE USE ONLY ---**

**INABILITY TO ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES**

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

- Patient is unresponsive
- Patient is injured
- Other (specify) \_\_\_\_\_

Signature of Representative: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_