community health centers OF BURLINGTON

PATIENT REGISTRATION FORM

Verified By:
DATE REC/ENTERED: ____/____/____
STAFF INITIALS: _____

APPOINTMENT TYPE/STAFF USE ONLY

☐ **MEDICAL** ☐ **DENTAL** ☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Keeler Bay

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form in **Black or Blue Pen Only***

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE

EMAIL ADDRESS

GENDER
☐ MALE ☐ FEMALE ☐ TRANSGENDER

GENDER FOR INSURANCE PURPOSES
☐ MALE ☐ FEMALE

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union

RACE
☐ African-American ☐ Native American
☐ Asian-American ☐ Pacific Islander
☐ Caucasian/White ☐ Multi-racial

Primary Language if Not English: _____
Do You Need Interpreter Services? ☐ YES ☐ NO

Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

Primary Care Physician

AGRICULTURAL WORKER
☐ Migrant ☐ Seasonal

Are You a U.S. Veteran?
☐ Yes ☐ No

FAMILY FINANCIAL INFORMATION
Family/Household Size: _____
Household Income: $ _____
As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

HOW DID YOU HEAR ABOUT US
☐ Hospital Referral ☐ Outreach Worker ☐ Friend ☐ Facebook
☐ Doctor/Dentist Referral ☐ Emergency Room Referral ☐ Work ☐ Other: _____
☐ Telephone Book ☐ Newspaper ☐ Website

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO
If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

☐ **Patient** (18 years or older) ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment) ☐ **Foster Parent** (proof of legal status required for treatment)

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | RELATIONSHIP TO PATIENT

DENTAL INSURANCE INFORMATION

☐ **I currently have DENTAL insurance (see below)**
☐ **I currently DO NOT have DENTAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Dental Insurance Name: _____
Policy/ID Number: _____
Group Number: _____
Billing Address for Insurance: _____
_____
Policy Holder's Name: _____
Policy Holder's DOB: _____
Policy Holder's Employer: _____
Phone Number for Insurance: _____

MEDICAL INSURANCE INFORMATION

☐ **I currently have MEDICAL insurance (see below)**
☐ **I currently DO NOT have MEDICAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Medical Insurance Name: _____
Policy/ID Number: _____
Group Number: _____
Billing Address for Insurance: _____
_____
Policy Holder's Name: _____
Policy Holder's DOB: _____
Policy Holder's Employer: _____
Phone Number for Insurance: _____

EMERGENCY CONTACT

NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER

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Consent to Treatment and Consent to Release of Health Information

for Treatment, Payment and Health Care Operations

I. Consent to Treatment

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Centers of Burlington, Inc. (CHCB). Treatment may include health screening, diagnosis, medical treatment, dental care; social services; and/or mental health and drug and alcohol screening, assessment, diagnosis and treatment.

II. Consent to Release of Health Information, including Health/Treatment Records for Treatment, Payment and Health Care Operations

I consent to the use within CHCB and the disclosure to persons or organizations outside of CHCB of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health and other treatment and health records and information (such health records and information are referred to in this Consent as my "Health Information") by CHCB for the following purposes:

A. Use of Health Information By or For CHCB for Treatment and for Health Care Operations:

- Providing treatment by CHCB staff;
- Conducting health care operations of CHCB including, for example, financial or quality assurance audits and training.

B. Disclosure of Health Information to Persons Outside CHCB for Treatment Purposes and for Payment

- Providing all necessary Health Information as determined by CHCB, including information about treatment for drug or alcohol abuse, to any of the following health providers if I am referred there for treatment: University of Vermont Medical Center, Allergy & Asthma Associates, Champlain Valley Foot & Ankle, Associates in Orthopedic Surgery, Appletree Bay Physical Therapy, Four Seasons Dermatology, Evolution Physical Therapy & Yoga, Hand Surgery Associates, Green Mountain Physical Therapy, or the Rehab Gym.
- Providing Health Information to other health providers or agencies not listed above who may be involved in my care (except for information concerning treatment for drug or alcohol abuse for which a separate consent is required);
- Obtaining payment for health care bills, including sending such Health Information as is needed to secure payment for CHCB services to the insurance company, worker's compensation company or agency that pays for my health services, as identified in my CHCB Registration form or other updated insurance information on file with CHCB.

III. Other Matters

I understand that I have the right to revoke this Consent at any time, but revoking this Consent will not affect any actions which were taken by CHCB in reliance on this Consent before I revoked it. If not previously revoked, this consent will terminate on the following date, event, or condition: _____. If none is indicated, this consent will terminate three years after the last date of services to me.

I understand that I may request restrictions on use or disclosure of my Health Information for the purposes described in this Consent and that CHCB may or may not agree to the requested restrictions. I also understand that except for those restrictions on use or disclosure of Health Information to which it agrees, CHCB will not be able to provide services to me (or the named patient) without this signed Consent.

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at CHCB.

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Patient Authorization

617 Riverside Avenue Burlington, VT 05401 Phone: (802) 864-6309 Fax: (802) 860-4324 www.chcb.org

I understand that, to the best of my knowledge, the demographic information I have provided is true and correct. **Initials:** ☐

I have read the Consent to Treatment & Consent to Release of Health Information and I understand and consent to its content. **Initials:** ☐

I hereby acknowledge that I have been offered a copy of CHCB's Payment Expectations document and understand and agree to adhere to these expectations. **Initials:** ☐

Assignment of Benefits
I hereby assign to CHCB any and all payments to which I am entitled under Medicaid or any health insurance policy for health care, behavioral health, or dental health services rendered to me by CHCB as long as the charges for services by CHCB do not exceed CHCB's regular charges. I further authorize CHCB to bill and receive payment directly from Medicaid or my insurance carrier(s) for those services that CHCB delivered and for which I may be entitled to insurance coverage. I also authorize CHCB to give Medicaid or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as I have received or am receiving primary health care, behavioral health, or dental health services.

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and times, test results, or information about prescriptions, CHCB will not give that information out unless his/her name(s) is provided for our records.

If you wish for your health information to be shared with a third party, complete a Combined Authorization Form. I understand that this information will be available to that party(s) until revoked in writing or until I am no longer a patient at the Community Health Centers of Burlington.
Initials: ☐

Patients at the Community Health Centers of Burlington consent to disclosure of information for purposes of treatment, payment, and health care operations. Patient may consent to receipt or disclosures of health care information for other purposes as well.

Patients requesting information in regards to drug and alcohol counseling/treatment need to complete a separate authorization. No drug and alcohol information will be given out with this permission.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand how CHCB may and may not use my protected health information in accordance with privacy law. **Initials:** ☐

By providing CHCB with my email address I am giving my permission for CHCB to exchange information with me via email or through an online portal, unless otherwise indicated here _____. **Initials:** ☐

REQUIRED

Name of Patient:_____ Date of Birth _____

Patient Signature:_____ Date: _____

Parent/Guardian: _____

Parent/Guardian Signature:_____ Date: _____