Community Health Programs
Patient Registration

Last Name: _____

First Name: _____

Preferred Name: _____

Middle Initial: _____ **Suffix**: _____ **Former Last Name**: _____ **Gender**: ☐ Male ☐ Female

Date of Birth: _____/_____/_____ **Social Security Number**: _____

Mailing Address: _____

Zip Code: _____ **City**: _____ **State**: _____

Home Phone (___) _____ **Mobile Phone** (___)_____ **Work Phone** (___)_____

Patient Email: _____

Language: ☐ English ☐ Other: _____ (specify)

Race: ☐ Hispanic or Latino/Spanish ☐ White ☐ African American/Black ☐ Asian
☐ American Indian/Alaska Native ☐ Other: (please specify) _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Home Bound: ☐ Yes ☐ No

Primary Care Provider: _____

Native Hawaiian: ☐ Yes ☐ No

Public Housing: ☐ Yes ☐ No

INCOME LEVEL: See Next Page for Income Guidelines **** Required by Department of Public Health and Human Services****
PLEASE CHECK THE APPROPRIATE BOX: ☐ 100% and below ☐ 101%-150% ☐ 151%-200% ☐ 201% and above ☐ Unknown

Agricultural Worker: ☐ No ☐ Seasonal ☐ Migrant

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

Homeless Status: ☐ Not homeless ☐ Doubling up ☐ Homeless Shelter ☐ Street ☐ Transitional ☐ Other ☐ Unknown

Veteran Status: ☐ Yes ☐ No

Are you or your family members WIC participants? ☐ Yes ☐ No

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

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*): _____

Guardian Middle Name (*if applicable*): _____ **Guardian Suffix** (*if applicable*): _____

Emergency Contact Name: _____

Emergency Contact Relation: _____

Emergency Contact Phone: (_____) _____ **Mobile Phone**: (_____) _____

Next of Kin Name: _____

Next of Kin Relation: _____

Next of Kin Phone: (_____) _____

Patient's Employer Name: _____

Patient's Employer Phone: (_____) _____

Patient's 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

Guarantor Information: (Person responsible for paying bills not covered by insurance - may or may not be the Policy Holder of the Health Insurance).

Last Name: _____ _____

First Name: _____ **Middle Initial**: _____ **Suffix**: _____

Date of Birth: ___/___/____

Mailing Address: _____

Zip Code: _____ **City**: _____ **State**: _____

Social Security Number: _____/_____/_____ **Phone**: (_____) _____

Email Address: _____

Guarantor Signature: _____

Policy Holder Information: (Subscriber of the Health Insurance Policy).

Last Name: _____ _____

First Name: _____ **Middle Initial**: _____ **Suffix**: _____

Date of Birth: ___/___/____

Mailing Address: _____

Zip Code: _____ **City**: _____ **State**: _____

Social Security Number: _____/_____/_____ **Phone**: (_____) _____

Email Address: _____

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.

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**	
Insurance Plan Type		**Insurance Plan Type**	

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 Message – If you want to receive text messages you must be registered for the Patient Portal (Please note that misuse of the portal may result in restriction at any time).

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

As a non-profit organization, we may also contact you as part of a fund-raising effort, but we 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 Telephone: _____

Work Telephone: _____

Cell Phone: _____

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

Would you like to register for the Patient Portal? ☐ Yes ☐ 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 any 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: