COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA

REGISTRATION FORM

Preferred Care Provider (Family doctor or nurse practitioner) _____Date _____

MR# _____

PATIENT INFORMATION

All sections must be completed.

Patient Last Name	First	Middle Initial	Email	Social Security #	Phone Number

Is this your Legal Name? Y N	If not, state your legal name	Former Name	Birth Date	Age	Gender M F

Street Address	PO Box	City	State	Zip Code

Is Patient Employed? (Circle Any That Apply) Full-Time Part-time Unemployed Temporary Seasonal Employment Related to Agriculture? Y or N	Occupation	Employer/Phone	Student Status NA Full-time Part-time

Marital Status S M Div Sep Wid	Military Status Active Veteran None	**The following information is needed for reporting purposes. All information will remain confidential.** Homeless Y N Number in Household: _____ Annual Household Income _____ Do You Wish To Be Evaluated For A Discounted Fee on Services? Y or N	**Race (Circle)** Caucasian American/Indian Asian Native Hawaiian Black/African American Other Pacific Islander More than one race **Circle one**: Hispanic Non-Hispanic

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST)

Name of Subscriber (if other than patient)	Subscriber Date of Birth	Subscriber Social Security #	Subscriber Address if Different from Patient	Subscriber Phone Number

Patient's Relationship to Subscriber: Self Spouse Child Other

Secondary Insurance Subscriber Name	Subscriber Date of Birth	Subscriber Social Security #	Subscriber Address if Different than Patient	Subscriber Phone Number

Responsible Party Name	**Address**	**Home Phone #**	**Date of Birth**

In Case of Emergency:

Name: Relationship:

Home Phone: Other Phone:

The above information is true to the best of my knowledge.

AUTHORIZATION TO THE TREATMENT & CARE: I, the undersigned named patient at Community Health Centers of Southern Iowa, hereby authorize the clinic and provider, and whomever he/she may designate as his/her assistant, to administer such treatment and perform such care as considered therapeutically necessary. I hereby certify that I have read and fully understand the authorization for Treatment and Care. I also certify that no guarantee or assurances have been made as to the results of the treatment and care received at Community Health Centers of Southern Iowa.

Signature _____ Date _____

(patient or legal guardian)

COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA

Acknowledgement of Receipt of Provider's Privacy Notice

Patient Name_____Date_____

DOB_____MR#_____

I, _____ acknowledge that I have access to a copy of Community Health Centers of Southern Iowa Notice of Privacy Practices which summarizes the way my identifiable health information may be used and disclosed by the Provider and states my rights with respect to my health information. I understand the Provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event the Provider revises the information practices, a revised Notice will be posted at the Provider offices and that I will be provided a current Privacy Notice by the Provider.

Patient has access to the following:

- HIPAA Privacy Individual Rights
- Consumer Rights, Choices, Responsibilities, Risks
- Notice of Privacy Statement
- Code of Ethics
- Service Description
- Grievance Procedure/Appeal Procedure

_____	_____	_____	_____
Signature of Patient/Guardian	Date	Signature of Witness	Date

If Guardian, State Relationship to Patient_____

Keeping Your Scheduled Appointment

As our patient, we ask that you assume the responsibility of informing our office if you are unable to keep a scheduled appointment.

Missed appointments will be documented, updated, and monitored by CHCSI Staff. Patients who are no call/no show will not be allowed multiple scheduled appointments until three consecutive appointments have been satisfied.

Patients who have three no call/no show appointments in a 12 month period will be required to provide the clinic with written rationale for continuing at this clinic and how the no call/no show issue will be remedied before another appointment is scheduled.

I have read this information about keeping my scheduled appointment and understand it.

_____	_____	_____	_____
Signature of Patient/Guardian	Date	Signature of Witness	Date

If Guardian, State Relationship to Patient_____

COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA

Information Release and Insurance Authorization

Patient Name_____Date_____

DOB_____MR#_____Insurance# _____

Standard Release of Information

1. I understand that the Center's medical record concerning me may be audited by Title XVIII (Medicare), Title XIX (Medicaid) if the cost of services is partially supported by those programs. I further understand that their representatives are sworn to maintain confidentiality as a condition of their employment.
2. I understand that the health record concerning me may be selected at random by the Division of Mental Health - Iowa Department of Social Services staff to review as part of the Center's accreditation site-visit. The purpose of these reviews is to help improve the services provided by the Center. I further understand that the reviewers subscribe to professional ethics concerning confidentiality.
3. I understand that information can be ordered released by the Courts; if I am involved with the Courts in any matter (specific concerns with Court Orders should be discussed with your therapist and/or attorney).
4. Employees of CHCSI will have access to your files for business purposes only. HIPPA Rules govern the disclosure of this information.
5. I understand that information concerning me shall be shared with no one else, except with my express knowledge and separate written consent.
6. I understand that I cannot be refused services if I refuse to sign this release of information, however I will then be responsible for the cost of services rendered.

FINANCIAL AGREEMENT/AUTHORIZATION TO PAY INSURANCE BENEFITS

I, the undersigned, whether acting as an agent or patient, agree that in consideration for the services rendered, do hereby assign payment directly to Community Health Centers of Southern Iowa of the clinic's benefits, otherwise payable to me, but not to exceed the clinics regular charges for this period of service. I further authorize the release of all information necessary to secure such payment and hereby agree to pay to Community Health Centers of Southern Iowa at its business office in Leon, Iowa any and all clinic charges that exceed or that are not covered by my insurance coverage. THIS AGREEMENT IS IRREVOCABLE during the period it is in force.

I consent to information being released as indicated above.

Signature _____ Date _____
(patient or legal guardian)

Witness _____Date _____

I refuse/withdraw my permission for the release of information to my insurance carrier and withdrawal my assignment of any insurance benefits provided, therefore assuming full responsibility of payment for care.

Signature _____ Date _____
(patient or legal guardian)

Witness _____Date _____

COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA

Consent to Leave Message

Patient Name_____Date_____

DOB_____MR#_____

Community Health Centers of Southern Iowa requires written consent for any patient who gives CHCSI permission to leave a message on their answering machine/voicemail in the event that we need to contact them. If we do not have written consent, we are unable to leave a message on any answering machine/voicemail or with a third party. It is our practice at Community Health Centers of Southern Iowa to call the last business day prior to a scheduled appointment as a courtesy to remind you of your upcoming appointment. We will also call if there are any changes in the schedule for an existing appointment.

PLEASE COMPLETE THE FOLLOWING:

I give consent for Community Health Centers of Southern Iowa to leave messages on my voicemail/answering machine at:

Home:_____ Mobile: _____Work:_____

I give consent for Community Health Centers of Southern Iowa to leave a message about my medical/behavioral/dental appointments with a third party individual:

Name: _____

Relationship: _____

Phone number_____

This consent is to remain in force from today _____/_____/_____ until further notice or cancellation by me.

Signature: _____ Date: _____
(patient or guardian)

COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA

Psychiatric &/ or Medical Advance Directive

Patient Name_____Date_____

DOB_____MR#_____

☐ I currently have a Psychiatric Advance Directive.

☐ I do not have a Psychiatric Advance Directive. I understand that I can follow-up on this option with the information provided below. If such a document is completed I will provide a copy to this agency.

☐ I currently have a Medical Advance Directive.

☐ I do not have a Medical Advance Directive. I understand that I can follow-up on this option with the information provided below. If such a document is completed I will provide a copy to this agency.

Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

What can be included in a Psychiatric Advance Directive?

- Crisis Symptoms
- Medication Choices
- Hospital Choices
- Emergency Contacts
- Relapse/Protective Factors
- Instructions to Staff
- Other Instructions
- For More information on what you can include in a Psychiatric Advance Directive, log on to www.nrc-pad.org

What can be included in a Medical Advance Directive?

- Crisis Symptoms
- Medication Choices
- Hospital Choices
- Emergency Contacts
- Relapse/Protective Factors
- Instructions to Staff
- Other Instructions
- Living Will
- Who do you want to make your health care decisions for you?
- Do you know enough about the kinds of treatments that can help keep you alive?
- How do you feel about the use of life support if you
- What concerns you the most?
- What does quality of life mean to you?

If you would like a copy of Iowa's Advanced Directive for Health Care Decisions, please ask the receptionist. It is strongly advised that you seek legal counsel when completing this document. Iowa currently does not have a specific Psychiatric Advance Directive Form.

Signature _____ Date _____
(patient or legal guardian)

COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA

Medicare Patients Only

Patient Name_____Date_____

DOB_____MR#_____

AN IMPORTANT MESSAGE FROM MEDICARE:

Please answer the following questions with Y (Yes) or N (No).

Do or did you or your spouse work for a company that provides you with health insurance? _____

Are you entitled to Medicare because of disability or end stage renal disease? (Dialysis) _____

Is this illness or injury the result of an automobile accident or other injury? _____

Is this illness or injury the result of an accident or illness that occurred at work? _____

Does the patient have a VA fee service card and has VA authorized treatment for this? _____

Are you entitled to benefits under the Federal Black Lung Program? _____

What is your retirement date? _____

The undersigned certifies that he/she has read the foregoing, and acknowledges his/her understanding of its contents, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

Signature _____ Date_____
(patient or legal guardian)

Witness _____ Date _____

If all are answered NO, Medicare is the primary payer. If any questions are YES, Medicare may be secondary.

COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA

INFORMED CONSENT for Mental Health TREATMENT

Patient Name_____Date_____

DOB_____MR#_____

1. I voluntarily agree to undergo mental health treatment and understand that I may end treatment at any time. I understand that my mental health provider may want to discuss this with me, but I reserve the right to stop treatment. Furthermore, I understand that my mental health provider will make diagnostic and treatment recommendations and if I do not agree with these I have the right to discuss them with my mental health provider.
2. I will be given a clear description from my mental health provider regarding the problems, personal strengths/limitations and treatment interventions that may be used during treatment.
3. I will be given a clear recommendation for the types of treatment recommended, such as individual therapy, group therapy, family therapy, addictions counseling, and/or psychiatric services. The frequency and length of appointments will be decided between me and my mental health provider.
4. I understand that my mental health provider cannot guarantee results or outcomes of mental health services. However, my mental health provider and I will develop clearly stated reasons, goals and objectives for continuing/discontinuing mental health treatment.
5. I understand that there may be some risk in participating in mental health services. These may include, but are not limited to, addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; re-uniting with family members; inconvenience of costs of counseling; and/or medication side effects. I am aware that I can discuss any risks with my mental health provider at any time.
6. I understand that I have the right to an interpreter if needed.
7. I understand that in the case of emergency, Community Health Centers of Southern Iowa maintains a 24 hour crisis line and I can find this number on my appointment card or by asking any staff member.
8. I understand that if I have a grievance with my mental health provider, I will first attempt to communicate this directly with him/her. In the event that the grievance is not satisfactorily resolved, I understand that I can complete a Grievance Form available from any staff member.
9. I understand that this Informed Consent form is not intended to be all inclusive; rather it is intended to provide some useful information before deciding to engage in mental health treatment. There may be additional questions regarding my mental health treatment and at any time I can ask for this information from my mental health provider.

I have reviewed this "Informed Consent for Mental Health Treatment" information with my mental health provider. I have been given the opportunity to ask questions about this information. A copy of this information is available upon request. By signing this, I indicate my understanding of this information.

_____ _____

Signature of Patient /Parent or Legal Guardian **Date**

_____ _____

Signature of Witness **Date**

COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA

TELEMEDICINE PATIENT CONSENT FORM

Patient Name_____Date_____

DOB_____MR#_____

I understand that I and/or a child in my care or custody will be participating as a telemedicine patient on the **Community Health Centers of Southern Iowa Video Network.** The purpose of telemedicine is to provide health care and education services over distance using videophone technology.

I understand that either myself or my caregivers will communicate via interactive videophone equipment with my healthcare providers. I further understand that I can request that the videophone service be discontinued at any time.

I authorize the release of any relevant medical information pertaining to me to the healthcare providers of his/her agents. I consent to the use of my name and the disclosure of any identifying information including but not limited to my age, social security number, and birth date that are required to conduct a medical encounter.

I further agree to be interviewed, and that this interview and my image may be videotaped, filmed, or photographed. I understand that these recorded images will be used for telemedicine program evaluation, research, and medical encounter purposes only, at both the transmitting and receiving facilities, and that my identity will not be disclosed except where medically necessary.

I understand that without prior written consent said recorded images will not be displayed, broadcast, or otherwise shown outside the health care setting.

I understand that the equipment provided would be for my use during the time I am a patient. I understand that I am not entitled to nor will I receive any royalties or other compensation for participating in telemedicine.

I have read this document carefully and I hereby consent to participate in the telemedicine project under the terms described above.

_____ _____

Signature of Patient /Parent or Legal Guardian **Date**

_____ _____

Signature of Witness **Date**

The above release is given on behalf of _____ because the patient is a minor or has been determined to be incompetent to make medical decisions or give medical consent.

_____ _____

Signature of Legal Guardian **Date**

If Legal Guardian, State Relationship to Patient_____