



PATIENT REGISTRATION FORM

Verified By: _____

DATE REC/ENTERED: ___/___/___

STAFF INITIALS: _____

APPOINTMENT TYPE/STAFF USE ONLY MEDICAL DENTAL

Riverside Safe Harbor Pearl Street South End Champlain Islands GoodHEALTH Winooski Family

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

LAST NAME	FIRST NAME	MI
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STREET ADDRESS	CITY	STATE	ZIP
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SOCIAL SECURITY #	DATE OF BIRTH	HOME PHONE	DAY PHONE
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EMAIL ADDRESS	PREFERRED CONTACT METHOD <input type="checkbox"/> PHONE <input type="checkbox"/> EMAIL <input type="checkbox"/> TEXT MESSAGE
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MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union	RACE <input type="checkbox"/> African-American <input type="checkbox"/> Native American <input type="checkbox"/> Asian-American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Multi-racial	Primary Language if Not English: _____ Do You Need Interpreter Services? <input type="checkbox"/> YES <input type="checkbox"/> NO Ethnicity/Ethnic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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Primary Care Physician	AGRICULTURAL WORKER <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal	Are You a U.S. Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	FAMILY FINANCIAL INFORMATION Family/Household Size: _____ Household Income: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
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GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER MALE <input type="checkbox"/> TRANSGENDER FEMALE <input type="checkbox"/> OTHER <input type="checkbox"/> DO NOT WISH TO REPORT	SEXUAL ORIENTATION <input type="checkbox"/> LESBIAN OR GAY <input type="checkbox"/> STRAIGHT/HETEROSEXUAL <input type="checkbox"/> BISEXUAL <input type="checkbox"/> SOMETHING ELSE <input type="checkbox"/> DON'T KNOW <input type="checkbox"/> DO NOT WISH TO REPORT	LEGAL SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.
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HOUSING STATUS Are You Homeless? YES NO
 If homeless, are you: Doubling Up (living with others) Shelter Street Transitional Unknown

EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
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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)

LAST NAME	FIRST NAME	MI
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STREET ADDRESS	CITY	STATE	ZIP
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DATE OF BIRTH	HOME PHONE
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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: _____

I currently have secondary DENTAL insurance (see below)

Dental Insurance Name: _____
 Policy/ID Number: _____

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: _____

I currently have secondary MEDICAL insurance (see below)

Medical Insurance Name: _____
 Policy/ID Number: _____



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.



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.

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

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.

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.

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.

I understand that the Community Health Centers of Burlington, Inc may use any e-mail address or mobile phone number provided to contact me for appointment reminders or other announcements. E-mail addresses and mobile phone numbers will not be sold to a third party or used for marketing purposes.

REQUIRED

Name of Patient: _____ Date of Birth _____

Patient Signature: _____ Date: _____

Parent/Guardian: _____

Parent/Guardian Signature: _____ Date: _____