Tri-Area Community Health

_____ LF _____ Floyd ____ Ferrum ____ Fries
_____ Troutdale _____ Stuart ____ City of Galax

Patient Registration Form

Please print clearly your response to all requested information. If you have questions, please ask. THANK YOU!!!

By providing your e-mail address and cell phone number, you may receive messages from Tri-Area Community Health. Messages can be stopped at your direction.

Patient Information

Patient's Full Name:_____ Sex at birth: M F
(FIRST) (MIDDLE INITIAL) (LAST)

Address:_____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ( )_____-_____ Work: ( )_____-_____ DOB:_____/_____/_____(mm/dd/yyyy)

Email Address:_____ Cell: ( )_____-_____ Are you a veteran? (circle one) Yes No

Social Security #:_____/_____/_____ Marital Status: (circle one) S M D W (Single/Married/Divorced/Widowed) Age:_____

Employer:_____ Phone No: ( )_____-_____

Employer's Address:_____
(STREET) (CITY) (STATE) (ZIP)

Responsible Party Information ____ Yourself ____Spouse _____Parent ____ Other

Name:_____
(FIRST) (MIDDLE) (LAST)

Physical Address:_____
(STREET) (CITY) (STATE) (ZIP)

Mailing Address:_____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ( )_____-_____ Work: ( )_____-_____ DOB:_____/_____/_____(mm/dd/yyyy)

Employer:_____ Phone No: ( )_____-_____

Employer's Address:_____
(STREET) (CITY) (STATE) (ZIP)

Insurance Information

Who is the insurance policy holder?: (circle one) Self Spouse Parent - Mother or Father

Name of Policy Holder:_____
(FIRST) (MIDDLE) (LAST)

Social Security # or Policy ID#:_____ Policy Holder DOB:_____

Emergency Contact

Emergency contact other than spouse:_____ Relationship to you:_____
(FIRST) (MIDDLE) (LAST)

Home Phone: ( )_____-_____ Work Phone: ( )_____-_____

PREFERRED PHARMACY: _____
City _____ Phone number _____

(Form continues on back)

AUTHORIZATIONS AND CERTIFICATIONS

I HEREBY AUTHORIZE THE FOLLOWING:

- *Tri-Area Community Health* through its appropriate personnel and/or its medical staff to perform, administer, prescribe, or to have performed, administered, or prescribed upon, to, or for me or any members of my family (including minor children) whose names appear below, such examination, tests, immunizations, injections, and diagnostic procedures as are deemed necessary. I also certify that all information contained herein is true and correct to the best of my knowledge and belief, and that no facts have been omitted.
- *Insurance Authorization and Assignment* to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.
- *Medicare Lifetime Authorization* for physical services and request that payment of authorized Medicare benefits to make either to me or on my behalf to Tri-Area Community Health, Inc., d.b.a. Tri-Area Community Health, for any services furnished to me by their physicians. I authorize my holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.
- *Deemed Consent for Designated Blood borne Pathogens:*
  Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (AIDS virus) testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility.
  Under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Tri-Area Community Health is directly exposed to body fluids of a patient in a manner which may transmit HIV (AIDS virus) or Hepatitis B and C according to the guidelines of the Centers for Disease Control, Tri-Area Community Health will proceed to test the patient's blood for HIV and Hepatitis B and C. Tri-Area Community Health will provide the results of the test to the patient through his or her primary care provider, and to the health care worker who was exposed. Tri-Area Community Health's policy also protects you as a patient, should you be exposed to the body fluids of a health care worker.
- *Rights of Minors*: Parents generally have the right to access their minor child's health records. However, Virginia laws gives minors additional privacy rights for records related to behavioral and reproductive health care services, including services related to mental health, birth control, pregnancy, and family planning. Your minor child may have rights to seek care and restrict access to their medical records for these types of services .
- *Patrick County Family Practice Patients (only)* in effort to coordinate patient care of patients seen in Stuart at Patrick County Family Practice records will be shared between Patrick County Family Practice and Tri-Area Community Health.
- *I ALSO CERTIFY* that I have read and understand the collection policy of Tri-Area Community Health and agree to abide by it._____(initials)
- *I ALSO CERTIFY* that I have read and understand the No Show Policy of Tri-Area Community Health and agree to abide by it._____(initials)

THE INFORMATION PROVIDED ON THIS REGISTRATION FORM IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:_____ DATE:_____

Payment Policy

Payments

Payment is due at the time of service. Co-pays cannot be waived. We accept cash, checks, bank cards, money orders, MasterCard, Visa, and Discover.

Insurance

We will submit claims to most major insurance carriers including Medicare and Virginia Medicaid. Please bring your insurance card with you to every visit so that we can ensure that our records are accurate.

If your insurance requires a referral or prior-authorization for you to be seen at Tri-Area Community Health, it is your responsibility to obtain prior to your visit. If not obtained, you will be responsible for the charges.

Specific questions regarding insurance coverage should be addressed by your carrier, or our business office may be able to assist you.

No Show Policy

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. If it is necessary for you to reschedule or cancel your appointment, please call us at least 24 hours prior to your scheduled appointment.

If you arrive after your scheduled appointment, you may be asked to reschedule your appointment, in order to accommodate patients that have arrived on time.

Patients with repeated no shows and last minute cancellations will be placed on an alternative appointment scheduling program. If placed on the alternative appointment scheduling program, patients may only schedule "same day" appointments as available and will not be allowed to pre-schedule appointments.

Tobacco/Vape Free Facility

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the
(Please Print Patient Name)

Notice of Privacy Practices from Tri-Area Community Health, Inc. at

Ferrum, Floyd, Fries, Galax, Laurel Fork, Troutdale and Stuart.

Signature: _____ Date: _____

OR

in lieu of patient signature, I, _____,
(Please Print Your Name)

a staff member of Tri-Area Community Health state that

_____ has been given our
(Please Print Patient Name)

current Notice of Privacy Practices.

Signature: _____ Date: _____

(FILE IN PATIENT MEDICAL RECORD)

Tri-Area Community Health

Tri-Area Community Health Centers

866-942-0401 Phone
276-398-3331 Fax

AUTHORIZATION FOR PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby give my permission to the person(s) listed below to receive information about my care:

NAME	RELATIONSHIP	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____
Signature of Patient, Parent or Guardian

_____
Relationship to Patient

_____
Date

Tri-Area Community Health

School Based Health Center Consent Form

Student's Name: _____**Date of Birth**: _____**SSN**: _____
School: _____ **Grade**: _____

Medical Care

Services Provided:

- Physical exams for school, sports & camp
- Treatment for acute & chronic illness & injuries
- Vision/hearing screenings and follow-up
- Referrals for specialty services
- Basic laboratory services & tests

I consent for my child to receive medical care through the School Based Health Center.
Does your child have health insurance? Y / N
Medical Insurance (choose one):
Medicaid #/Insurance: _____
Insured: _____
Name of insured parent, insurance name and policy #

Where do you take your child to see the doctor? _____
Phone #: _____ Date of last physical exam: _____
List of allergies to medicines, foods, bee stings, etc.: _____
If yes, does your child require an Epi-Pen? Y / N
List of current medications, dosage, and time taken: _____
_____ Pharmacy: _____
Does the child have any medical problems including learning/physical disabilities? Y / N If yes, please list.
_____
Does the child's siblings or parents have any medical problems? Y / N. If yes, please list. _____
_____
Has your child ever had any surgeries? Y / N If yes, describe: _____

What language is most often spoken at your home? _____
Is there any other important health information we should know? _____
_____
Would you like to request any other assistance, or have any comments to help the health center serve you better?
_____

May we leave a voicemail with NEGATIVE testing results? _____YES _____NO_____

PLEASE SIGN ON THE REVERSE SIDE

Parent/Guardian Information

Mother/Guardian: _____ DOB: _____ Home/Work Phone: _____
Father/Guardian: _____ DOB: _____Home/Work Phone: _____
Parent/Guardian address: _____
Email address: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

Authorization for Disclosure of Information

Following Health Insurance Portability and Accountability Act (HIPAA) rules, School Based Health Center staff members will use and share my Personal Health Information (HPI) for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the location(s) my child receives his/her health care services and on the Tri-Area Community Health (TACH) website.

In order for health center staff members to provide services, I authorize the school to release school records on a "need to know basis" to the School Based Health Center staff members, and also for the School Based Health Center staff members to release medical records to the school, the health department, and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may include, but is not limited to the following; immunizations records, class schedules, parental/guardian contact, address, phone number, medical and behavioral health conditions, health screenings, medications, health care plans, or attendance information. The medical and mental health providers from the School Based Health Center may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed above to release information to the School Based Health Center staff members as needed.

I understand that if my child requires the School Based Health Services, reasonable attempts will be made to contact me and if I cannot be reached, I give consent for my child to be seen by the providers at the clinic.

I hereby authorize the School Based Health Center to provide the services as indicated above. I authorize TACH to file my insurance for services rendered. I request that payment be made directly to TACH. I understand that I am responsible for all charges incurred regardless of my insurance status or lack thereof. Slide fee applications are available at www.triareahealth.org.

By signing this consent, I confirm I am the parent/legal guardian of the above listed student and am authorized to give this consent. This consent will be in effect for one year from this date.

_____

Parent/Guardian Signature **Date**