

Check **Location** Site: ☐ LF ☐ Floyd ☐ Ferrum ☐ Fries ☐ Troutdale ☐ Cana
Check **School Based** Site: ☐ City of Galax ☐ Carroll Co. ☐ Grayson Co

Tri-Area Community Health **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

Preferred Name: _____

Patient's Full Name: _____

(First)

(Middle Initial)

(Last)

Address: _____

(Street)

(City)

(State)

(Zip)

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

DOB: ____/____/____ (mm/dd/year) Sex at birth ☐ M ☐ F Social Security #: ____/____/____

E-Mail Address: _____

Employer: _____ Phone No. () _____ - _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Responsible Party Information ☐ Yourself ☐ Spouse ☐ Biological Parent ☐ Guardian ☐ Other (please list) _____

Name: _____
(First) (Middle) (Last)

Physical Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Cell Phone: () _____ - _____ Home: () _____ - _____ DOB: ____/____/____ (mm/dd/year)

MINORS: If patient is a minor:

Please list other parent/guardian if applicable _____

Is child in foster care? ☐ Yes ☐ No If Yes, please ask for Foster Care Form.

INSURANCE Information

Name of Insurance: _____

Name of Policy Holder: _____ Relationship to patient : _____

Policy ID #: _____ Policy Holder DOB: _____

Type of Insurance: ☐ Medicare ☐ Medicaid ☐ Other

Is there a secondary insurance? ☐ Yes ☐ No If Yes, please list: _____

Emergency Contact

Emergency contact other than spouse: _____ Relationship to you: _____
(First) (Middle) (Last)

Cell Phone: () _____ - _____ Work Phone: () _____ - _____

Preferred Pharmacy: _____

City: _____ Phone number: () _____ - _____

(Form continues on back)

The following information is for public health service grant purposes only. No personally identifiable information is ever reported. By providing this information, you help us continue to receive funding to provide services to the community and special populations. Please select answers below.

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Other _____

Race: (If more than one race, check all that apply):

- ☐ American Indian or Native Alaskan
- ☐ Black or African American
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ White
- ☐ More than one race
- ☐ Unreported/Choose not to disclose race

Ethnicity: Are you Hispanic or Latino? ☐ Not Hispanic, Latino or Spanish ☐ Unreported/Choose Not to Disclose
☐ Yes, Mexican, Mexican American, Chicano/o ☐ Yes, Puerto Rican ☐ Yes, Cuban
☐ Yes, Another Hispanic, Latino/a or Spanish origin

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ Is an interpreter needed ☐ Yes ☐ No

Are you a veteran? (circle one) Yes No

Do you move to different locations to work on a farm or in agriculture? ☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No
If yes, where do you sleep at night? ☐ Shelter ☐ Street ☐ Stay with a friend ☐ Other _____

Number of people in household: _____ Annual household income (please circle one below):

- 0-\$10,000

\$25,000-29,999

\$50,000-59,999
- \$10,000-14,999

\$30,000-34,999

\$60,000-69,999

Choose not to disclose
- \$15,000-19,999

\$35,000-39,999

\$70,000-79,999
- \$20,000-24,999

\$40,000-49,999

\$80,000-above

Where did you hear about Tri-Area? ☐ College ☐ Community Event ☐ Family/Friend
☐ Health Dept/DSS ☐ Newspaper ☐ Website/Facebook, etc.
☐ Other _____

(Form continues)

AUTHORIZATIONS AND CERTIFICATIONS

I HEREBY AUTHORIZE THE FOLLOWING:

- **Tri-Area Community Health (TACH)** - 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.
- **Medical Lifetime Authorization Medical** – for physical services and request that payment of authorized Medicare benefits to make either to me or my behalf to Tri-Area Community Health, Inc., d.b.a. Tri-Area Community Health (TACH), 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.
- **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 given by the Virginia State Code to seek care and restrict access to their medical records for these types of services.
 - School Based Programs will follow the rules as established by the Governor of Virginia.
- **School Based Program** - Please complete the School Based Health Center Consent Form which provides additional information for the treatment of your child.
- **Deemed Consent for Designated Blood borne Pathogens** - In the event, that TACH staff comes in contact with my or my children's body fluids, I _____(initial) consent to be tested for HIV, Hepatitis B and C.

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)

I ALSO CERTIFY that I understand that Legal Fees for Court Appearances for Providers of Tri-Area Community Health are in place and the fee schedule can be obtained upon request. _____(initials)

I ALSO CERTIFY that I understand that abuse against staff or other patients will not be tolerated. This includes assault, threats, verbal harrassment or cursing, or sexual language or unwatned touching. Violators may be permanently dismissed from our practice.

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

SIGNATURE: _____ **DATE:** _____



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

Please Note: The parent of a minor child has access to their child's PHI unless there is a court order stating otherwise or if the patient is a minor that falls under Virginia law asking for privacy. Court papers and/or court orders are to be provided prior to removing a parent's access, changes cannot be made without the proper legal documents. i.e., access cannot be blocked for one parent on the word of another parent.

When the patient turns 18, a new request and consent is required.

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

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)
