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)

Form continues to page 3

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)

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

Behavioral Health Care

Services Provided:

- Talk therapy to address mental health concerns
- Tools for improved emotional regulation, coping skills, and social skills
- Referrals for specialty services

I consent for my child to receive 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**