

Check **Location** Site:  LF  Floyd  Ferrum  Fries  Troutdale  Cana  
Check School-Based Site:  Carroll  Floyd  Galax  Grayson  Patrick

 **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):

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian or Native Alaskan | <input type="checkbox"/> Native Hawaiian                               |
| <input type="checkbox"/> Black or African American         | <input type="checkbox"/> Other Pacific Islander                        |
| <input type="checkbox"/> Asian Indian                      | <input type="checkbox"/> Guamanian or Chamorro                         |
| <input type="checkbox"/> Chinese                           | <input type="checkbox"/> Samoan  |
| <input type="checkbox"/> Filipino                          | <input type="checkbox"/> White   |
| <input type="checkbox"/> Japanese                          | <input type="checkbox"/> More than one race                            |
| <input type="checkbox"/> Korean                            | <input type="checkbox"/> <b>Unreported/Choose not to disclose race</b> |
| <input type="checkbox"/> Vietnamese                        |  |
| <input type="checkbox"/> Other Asian                       |  |

**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):

- |  |  |  |                               |
|--|--|--|-------------------------------|
| <input type="checkbox"/> 0-\$10,000      | <input type="checkbox"/> \$25,000-29,999 | <input type="checkbox"/> \$50,000-59,999 |                               |
| <input type="checkbox"/> \$10,000-14,999 | <input type="checkbox"/> \$30,000-34,999 | <input type="checkbox"/> \$60,000-69,999 | <b>Choose not to disclose</b> |
| <input type="checkbox"/> \$15,000-19,999 | <input type="checkbox"/> \$35,000-39,999 | <input type="checkbox"/> \$70,000-79,999 |                               |
| <input type="checkbox"/> \$20,000-24,999 | <input type="checkbox"/> \$40,000-49,999 | <input type="checkbox"/> \$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)

\_\_\_\_\_



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](http://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**