Community Health Center of Fort Dodge

Family	Last	First	MI	Birth date	Sex M-F	Race	Marital Status	Social Security #
Patient								
Responsible Guardian								
Spouse or Significant other								

Address:_____ **City:** _____**State: ____Zip Code:**_____

County: _____ **Telephone (H)** _____ **(W)** _____**Cell** _____

Email Address:_____

Responsible Party Arrangement (proof of Custody Agreement/Dependent Adult Guardianship may be requested):
#1Parent Name:_____Phone:_____
Custody(circle): Primary / Secondary / Equal / Suspended / Terminated
#2Parent Name:_____Phone:_____
Custody(circle): Primary / Secondary / Equal / Suspended / Terminated
Guardian:_____Phone:_____
Description of Legal Authority:_____

Emergency Contact Name(Person to contact in an emergency NOT living in your household

Name: _____Telephone:_____Relationship:_____

I authorize CHCFD to release my general information to the following:

(example: appointment times/pick up prescriptions/book or cancel appointments)

Name: _____Telephone:_____Relationship:_____

Name: _____Telephone:_____Relationship:_____

Name: _____Telephone:_____Relationship:_____

Military Status: **None□ Active□ Retired□ Veteran□** **Student Status:** **None□ Part-time□ Full-time□**

Hispanic/Latino Ethnicity? Yes □ No □ Email: _____

Housing Status (please check one) **Own□ Rent□ Live with friends/family □ Homeless □**
*If you rent do you receive rental assistance (HUD, MIRHA, Shelter plus Care, other)? **Yes □ No □**

If employed, please let us know where_____ Full Time□ Part Time□ Self Employed□ Retired □ Unemployed□

DO YOU WISH TO BE EVALUATED FOR A DISCOUNT? **YES NO**
If yes please ask for information for income verification from our Financial Advocate.

TURN OVER TO COMPLETE REGISTRATION

Please estimate your income information below. **We only collect this information for our federal grant purposes to continue to received funding for those who are uninsured and need our services.** Please help us in maintaining our safety net services for those who need medical care. Your name will not be used when reporting for our grant purposes, nor will it be shared with any other entity. Please check your income level according to your household size.

Household Size	Monthly Income Level			
1	< $903 □	< $1353 □	< $1804 □	$1805 + □
2	< $1214 □	< $1820 □	< $2427 □	$2428 + □
3	< $1526 □	< $2288 □	< $3051 □	$3052 + □
4	< $1838 □	< $2755 □	< $3674 □	$3675 + □
5	< $2149 □	< $3223 □	< $4297 □	$4298 + □
6	< $2461 □	< $3690 □	< $4921 □	$4922 + □
7	< $2773 □	< $4158 □	< $5544 □	$5545 + □
8	< $3084 □	< $4625 □	< $6167 □	$6168 + □

Gender Identity: Circle one

Identifies as Male
Identifies as Female
Female to Male
Male to Female
Genderqueer neither exclusively Male or Female
Additional gender category or other please specify

Sexual orientation: Circle one

Straight or heterosexual
Lesbian, gay, or homosexual
Bisexual
Something else please describe
Don't know
Choose not to disclose

How did you hear about us?
□ Television □ Radio □ Newspaper □ Brochure □ Patient/Physician Referral
□ Social Media □ Other: _____

How would you like us to contact you about appointments? Phone Call or Text

I authorize CHCFD to leave a detailed message on my phone(circle one)**: Yes No**

Payment Agreement: I hereby certify that the above information is true and that I have reported all sources of income being received to support my family. I agree to promptly and fully pay any charges for services supplied and provided by Community Health Center of Fort Dodge,INC according to the fees established. **I agree to promptly pay for charges considered non covered or my responsibility by my insurance companies after the claim has been processed**. In the event of non-payment, failure to comply with terms of my payment plan or do not make a payment plan, I will be responsible for any late fees associated with my past due bill. I have read all the above terms and hereby assume responsibility for paying any charges according to these terms.

Assignment of Benefits: I hereby assign and authorize direct payment to Community Health Center of Fort Dodge,INC of all insurance coverage or other benefits under any government program, any insurance policy or plan, or any other available benefit. This assignment shall remain in effect until revoked in writing.

Consent to Medical Treatment: I hereby request and give consent for the health care professionals at Community Health Center of Fort Dodge,INC to provide medical treatment to me and/or my family.

Consent to Release Protected Health Information: I authorize Community Health Center of Fort Dodge,INC to release medical information relating to the patient to health insurance companies, health plans or third party payers, or their authorized agents, for the purpose of determining benefits payable in connection in connection with services provided.

_____ _____

Patient or Responsible Party Signature *Date*

_____

Printed Name

_____

Description of Legal Authority to Act on Behalf or Patient

About Our **Notice** of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice or Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this notice.
- The person to contact for further information about our privacy practices is our security officer.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices:

Patient Date of Birth:_____
Patient Name(printed):_____Date:_____

_____ _____
Patient or Responsible Party Signature Date

_____
Description of Legal Authority to Act on Behalf or Patient

Full Privacy Practice is available upon request.

Community Health Center of Fort Dodge, Inc.

Missed Appointment Agreement

_____ _____

Printed Patient Name **Birthday**

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or late canceling an appointment means we are unable to fill this appointment time with another patient who desperately needs care.

Our policy requires **(initial each box after reading**):

☐ **Appointment Confirmation**: You must text/call to confirm your appointment the business day before. Our practice closes at 5:00pm. It is your responsibility to call. If you do not call to confirm we will give your appointment away to another patient. This will be considered a missed appointment.

☐ **Timely Cancellations**: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment.

☐ **On Time Arrivals**: If you are more than 15 minutes late to your appointment, we may give your appointment away to another patient. This will be considered a missed appointment.

☐ **Compliance:** Patients are only allowed THREE missed appointments in a 12 month period. After the third missed appointment, you will not be scheduled appointments, but are welcome to use our clinic as a "same-day" patient.

Many patients use Community Health Center of Fort Dodge Inc. services. Your help in keeping your appointments enables us to provide better and timelier care for all our patients.

_____ _____

Patient or Parent/Guardian Signature ***Date***

_____

Description of Legal Authority to Act on Behalf of Patient