CHRIST COMMUNITY HEALTH

For Office Use
Entered by: _____
Date: _____

New Patient Packet

Patient Information

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
May we leave a voicemail? ❒ Yes ❒ No *May we leave a voicemail?* ❒ Yes ❒ No *May we leave a voicemail?* ❒ Yes ❒ No

Date of Birth: _____ Gender: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

Patient SSN: _____ Email Address: _____

Employment: ❒ Full-time ❒ Part-time ❒ Student ❒ Retired ❒ Active Military ❒ Unemployed Number of people in your household: _____

How often are you paid? ❒ Weekly ❒ Biweekly ❒ Monthly ❒ Annually Gross income *(before taxes)* during the period: $ _____

Patient Race: ❒ American Indian/Alaska Native ❒ Asian ❒ Native Hawaiian ❒ Black/African American ❒ White ❒ Other Pacific Islander

Patient Ethnicity: ❒ Hispanic/Latino ❒ Not Hispanic/Latino Patient Primary Language: ❒ English ❒ Spanish ❒ Other _____
Do you require translation? ❒ yes ❒ no

Are you a Veteran? ❒ yes ❒ no
Are you an Agricultural Worker? ❒ yes ❒ no
Are you Homeless? ❒ yes ❒ no If yes, what is your status? ❒ Street ❒ Doubling up ❒ Transitional Housing ❒ Shelter ❒ Other
Are you a Public Housing Resident? ❒ yes ❒ no

Emergency Contact
Relation to Patient: _____
Name: _____
Address: _____
Phone: _____
May we leave a voicemail on this phone? ❒ Yes ❒ No

Primary Pharmacy
Name: _____
Address: _____
Phone: _____
Fax: _____

Reason for Seeking Care: _____
Please list any medical conditions or information that could help us provide better care to you:
_____

Insurance Information *(Please present insurance card to front desk)*

Primary Insurance
Carrier Name: _____
Policy Holder ID: _____
Group #: _____ Copay ($): _____

Subscriber Name: _____
Relation to Subscriber: _____
DOB: _____ Gender: ❒ Male ❒ Female
❒ I have other family that goes here ❒ I am a patient here too

Secondary Insurance
Carrier Name: _____
Policy Holder ID: _____
Group #: _____ Copay ($): _____

Subscriber Name: _____
Relation to Subscriber: _____
DOB: _____ Gender: ❒ Male ❒ Female
❒ I have other family that goes here ❒ I am a patient here too

Responsible Party *(please complete if other than the patient)*

The patient is my: ❒ Self ❒ Spouse ❒ Child ❒ Grandchild ❒ Other
Name: _____ Address: _____
Phone: _____ DOB: _____ Gender: ❒ Male ❒ Female
May we leave a voicemail on this phone? ❒ yes ❒ no

_____ _____
Patient or Guardian Signature **Date**

CHRIST COMMUNITY HEALTH

Privacy Policy Acknowledgement (Health Insurance Portability and Accountability Act: HIPAA)

Patient Name (Last)	(First)	(Middle Initial)	Date of Birth

I have had the opportunity to review the Notice of Privacy Practices for PHI (Protected Health Information) before signing this consent. I give permission to Christ Community Health Services Augusta (CCHSA) to disclose information about myself (or another person for whom I have the authority to sign) for the purposes of treatment, payment, and healthcare operations. I also authorize Christ Community Health Services Augusta to communicate with the following individuals about my condition or treatment. I understand that I have the right to restrict how the Practice discloses my PHI, and that I can revoke this authorization at any time.

May we leave a voicemail or text *(if applicable)* **on your:**
Home Phone? ❒ Yes ❒ No
Cell Phone? ❒ Yes ❒ No
Work Phone? ❒ Yes ❒ No

I give permission to CCHSA to communicate with the following individuals regarding my condition or course of treatment:

Emergency Contact Name	Relationship to Patient	Phone Number	May we leave a voicemail? ❒ Yes ❒ No
Guardian Completing Form *(if applicable)*	Relationship to Patient	Phone Number	May we leave a voicemail? ❒ Yes ❒ No
Name	Relationship to Patient	Phone Number	May we leave a voicemail? ❒ Yes ❒ No
Name	Relationship to Patient	Phone Number	May we leave a voicemail? ❒ Yes ❒ No

_____ _____
Patient or Guardian Signature **Date**

Authorization, Assignment, Financial, No-Show, and Pain Management Policy

1) I do hereby voluntarily consent to medical care at Christ Community Health Services, Augusta (CCHSA). I hereby authorize all physicians and their assistants including Physician Assistants and Nurse Practitioners employed by CCHSA to use such diagnostic and treatment procedures they deem necessary for proper medical management and treatment. I understand that Physician Assistants and Nurse Practitioners are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician.
2) I also assign the claim payments to be made payable to CCHSA.
3) I agree to the release of information to Medicare, Medicaid, and third party payers. I understand that some of the services that may be ordered may not be covered under Medicare, Medicaid, and other insurance and I am responsible for any amounts not paid.
4) I understand that payment in full is expected before services are rendered. I understand that insured patients must pay their copay, and uninsured patients must pay their sliding fee charge.
5) I understand that patients must provide proof of income in order to qualify for sliding fee scale.
6) I understand that if I am a new patient, and I do not come to my first appointment, I may only reschedule one time. If I do not come to this second new patient appointment, I will not be able to schedule another appointment for a year.
7) After coming to my first appointment, I am then considered an established patient. I understand as an established patient, that if I No-Show more than two appointments in a 12-month period, I may be terminated from this practice. I understand that it is my responsibility to call to cancel or reschedule the day before my appointment by 3pm, and that not doing so will result in a No-Show. Showing up without payment in full or more than 15 minutes late will also result in a No-Show. It is my responsibility to call to cancel or reschedule the day before my appointment if payment in full cannot be provided.
8) I understand that CCHSA will not fill narcotic prescriptions on a first appointment, nor do they guarantee that they will continue a current narcotic prescription.

_____ _____
Patient or Guardian Signature **Date**

CHRIST COMMUNITY HEALTH

127 Telfair St • 1226 D'Antignac St • Augusta, GA 30901 • 706-922-0600

Please fill out this form to ensure you are receiving all of the discounts we offer. We want to provide you with the most affordable primary care no matter your income or insurance status.

❒ *By checking the box, I decline to disclose my income and decline all possible sliding fee discounts.*

Sliding Fee Scale Application

First Name | Middle Initial | Last Name | Social Security No.

Present Address | Street | City | State | Zip

Telephone Number | Mobile Phone | Email Address

Household Members and Income: Please List all household members including ***yourself*** below. List additional family members on the back of this form.

Household Members			Paycheck	Unemployment	Social Security/ Disability	Food Stamps	Alimony/Child Support	Assistance from friends	Other	**Total Monthly Income**
Full Name	**Relation to you**	**Date of Birth**								
Ex. John F. Doe	***Self***	***1-1-10***	*$ 450*	*$ 0*	*$ 0*	*$ 200*	*$ 0*	*$ 100*	*$ 0*	*$ 750*

Total in Household: _____ **Total Monthly Household Income:** _____

Attention

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Christ Community Health Services Augusta, Inc. if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Christ Community Health Services Augusta, Inc. I hereby acknowledge that I read the foregoing disclosure and understand it.

_____ _____

Signature Date

Please provide one of the following from part A and

A. Proof of Identification

1. Driver's License
2. Valid Government ID
3. Current Utility Bill
4. SSN or Birth Certificate

B. Proof of Income (If not applicable, go to Section C)

1. Recent Federal Income Tax Return
2. Recent Stub for one month

C. Proof of *NO* Income

1. Notarized statement from person(s) who provide your financial support.
2. Statement from Social Security stating that you do or do not receive benefits
3. Statement from the department of Family and Children Services stating you do or do not receive benefits
4. Letter from public facility verifying residency and/or income.

CHRIST COMMUNITY HEALTH

Why should I have a primary care provider (PCP) when I feel well? If I get sick, I can go to the local emergency room (ER) or urgent clinic for whatever I need.

In our country the number of 'Urgent care' clinics is growing and emergency rooms are often the only place people go when they get sick. Sometimes people don't see a reason to have a primary care provider (PCP). Sometimes people think an ER or Urgent care will be quicker and have everything they need.

Even though many people may think this way, primary care medicine provides something an urgent care clinic or ER was never designed to offer—a relationship, a place to be known.

By developing this relationship, you have a health care team that has all the information they need to figure out problems and make good recommendations. In other words, this relationship can be important when choosing the correct treatment plan. A PCP is also like a 'quarter-back' who can coordinate your healthcare team. Sometimes this team involves complicated tests and specialty doctors.

PCPs offer a wide variety of important services, including preventive care, such as cancer screenings; and care for conditions like diabetes or high blood pressure, among many others. PCPs are also able to deal with many urgent concerns, and, perhaps most importantly, are able to do this better because they know your history and the values that are most important to you.

It is easy to worry about today and not to think about tomorrow—like the 40 year old person with high blood pressure who does not go to the doctor because he 'feels well'. He may not realize that high blood pressure can cause a stroke or heart attack. A simple visit to a PCP could help him learn how to prevent something like this from happening. A PCP addresses today's problems and also helps you plan for your future.

Now is the time to start a relationship with your own primary care provider. At Christ Community Health Services Augusta, we treat the whole person—mind, heart, spirit, and body. We are committed to sharing the love of Christ through the care we provide.

Sincerely,
The Staff of Christ Community Health Services Augusta

Christ Community Patient-Provider Responsibilities

Our mission is to "proclaim Jesus Christ as Lord and to demonstrate His love by providing affordable, quality, primary care."

PROVIDER Responsibilities:

- Listen to our patients' concerns and give appropriate advice.
- Make sure the management and treatment plans for our patients' health are clear.
- Make sure our patients have a good understanding of all medications prescribed and their treatment plan goals.
- Refer our patients as needed to specialists.
- Make sure our patients receive medical care when the office is open by providing Same Day Appointments.
- Make sure our patients have access to medical advice when the office is closed by having a provider on call and available by phone.
- Give illness specific written educational materials to assist in self-management.
- Explain our financial policies and make care affordable.
- Give our patients information about acquiring medical insurance.
- Provide our patients with information about behavioral health resources in our community.
- Assist our patients in gathering medical records from previous providers.

PATIENT Responsibilities:

- Ask questions about your illness and take an active role in your care.
- Give a detailed and honest medical history of your entire family.
- Give an update of any changes in your health each visit.
- Take all medications prescribed as directed by your provider and provide information about over the counter and herbal medications you are taking.
- Keep all scheduled appointments with your provider and other specialist(s).
- Cancel appointments by **3pm the day before** an appointment if needed.
- Discuss and be involved in your treatment plan with your provider.
- Call your provider first with medical problems, unless it is a medical emergency.
- Avoid using the Emergency Room in non-emergency situations.
- Bring all discharge papers from Emergency Room and Hospital stays to your appointments.
- Inform your provider of all self-referred visits or special test(s). Bring documents when available.
- Provide personal email address for easy access and contact.

Important Information:

Website: www.cchsaugusta.org
Phone: 706-922-0600
Insurance Navigator: 706-396-1467

Regular Hours

Laney Walker Community Health Center:
1226 D'Antignac Street
Augusta, GA 30901

Monday	8:30am-5:00pm
Tuesday	8:30am-5:00pm
Wednesday	9:00am-5:00pm
Thursday	8:30am-5:00pm
Friday	8:30am-5:00pm

Olde Town Community Health Center:
127 Telfair Street
Augusta, GA 30901

Monday	8:30am-5:00pm
Tuesday	8:30am-5:00pm
Wednesday	9:00am-5:00pm
Thursday	8:30am-5:00pm
Friday	8:30am-5:00pm

After Hours/Quick Sick:

Olde Town Community Health Center:

Tuesday	5:00pm-7:00pm
Thursday	5:00pm-7:00pm

Interpretive Services are available for multiple languages and hearing impaired.

Patient Portal is available for all patients. A valid email address is required for registration. Please talk to our front office to register. Portal will allow you to have quick access to medication refills, medical advice, and requests for appointments.

An Insurance Navigator is available to help register for affordable insurance.

Medical Advice

Christ Community offers medical advice for patients during and after office hours. During office hours please call our main number and follow the prompts to speak to our triage nurse.

After hours please call our main number and you will be connected to our on call physician.

Reviewed: 11-10-16