CHRIST COMMUNITY HEALTH

To proclaim Jesus Christ as Lord and to demonstrate His love
by providing affordable, quality primary health care.

Welcome to Christ Community Health Services!

Thank you for choosing us to be your healthcare partner and entrusting us with your care. Our goal is to provide the highest quality, most compassionate care to our patients and their loved ones.

To make sure your first visit goes smooth, with the most time spent on you, please fill out the enclosed forms before you come to your visit and bring them with you.

Please arrive 30 minutes early to register at our reception area. You must bring a valid photo ID. Accepted forms of photo IDs include a state-issued driver's license, state issued identification card or a passport. Proper patient identification protects your security and privacy.

If you have insurance, please bring your insurance card with you. We will need a copy of it to make sure we can bill your insurance company.

We have also enclosed an application for our discount program. You can apply for help and reduce the amount you must pay for your care. Please complete it also before coming and please be sure to bring the documents that show how much money you make so we can determine if you can be approved for our sliding fee schedule. You can apply for this whether you have no insurance or if you need some help with your insurance out of pocket amounts.

Please also bring all of your prescription and over-the-counter medications with you at each visit.

If for any reason you find that you are unable to keep your scheduled appointment, please call our office at least 24 hours in advance of the visit.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you.

Sincerely,

The Christ Community Health Team

Patient Information

Patient Name	Last	First	Middle Initial	Date of Birth

Home Address	House #	Street	Apt #	City	State	Zip

Mailing Address	House #	Street	Apt #	City	State	Zip

☐ Check this box and leave mailing address blank if it is the same as your home address

Email Address		
	May we contact you via email? (circle one)	Yes | No

Home Phone		
( ) -	May we leave a voicemail? (circle one)	Yes | No

Cell Phone		
( ) -	May we leave a voicemail? (circle one)	Yes | No
	May we send a text message? (circle one)	Yes | No

Work Phone		
( ) -	May we leave a voicemail? (circle one)	Yes | No

Gender: Female | Male	Social Security #: - -

Pharmacy Name:

Insurance Information (Please copy this information from your insurance card)

☐ Check this box if the patient does not have any health insurance.

Primary Insurance

Carrier (Company)	Group ID	Office Visit Copay
		$

Subscriber Name	Subscriber Date of Birth

Policy Holder ID (for the patient)	Subscriber's Relation to Patient (circle one)
	Self | Spouse | Partner | Child | Other _____

Secondary Insurance

Carrier (Company)	Group ID	Office Visit Copay
		$

Subscriber Name	Subscriber Date of Birth

Policy Holder ID (for the patient)	Subscriber's Relation to Patient (circle one)
	Self | Spouse | Partner | Child | Other _____

Patient Information (page 2)

Responsible Party

☐ I am the patient. (You may skip this section; go to additional Information)

If you are the parent/legal guardian or are otherwise responsible for authorizing care and paying bills for the patient named above, please provide your name and contact information below.

The patient is my (circle one): Spouse | Partner | Child | Other _____

Name	Last	First	Date of Birth	SSN

Mailing Address	House #	Street	Apt #	City	State	Zip

Email Address

Additional PATIENT Information

Please circle one option for each question below. We are required to ask these questions, but you may skip any you are not comfortable answering.

Marital Status? Single | Married | Partner | Widowed | Divorced | Legally Separated

Employment Status? Full-time | Part-time | Not Employed | Self-Employed | Retired | Active Military | Student

Race? American Indian/Alaska Native | Asian | Native Hawaiian/Other Pacific Islander | Black/African American | White/Caucasian

Ethnicity? Hispanic/Latino | Not Hispanic/Latino

Primary Language? English | Spanish | Other _____
Do you require interpretation services? Yes | No

Are you a veteran? Yes | No

Are you a public housing resident? Yes | No **If yes, which housing development?** _____

Are you homeless? Yes | No **If yes, what is your status?** Street | Doubling Up | Transitional Housing | Shelter _____

Is your main employment in agriculture on a seasonal basis (Seasonal Agricultural Worker)? Yes | No

Do you move (migrate) through the year for agricultural work (Migratory Agricultural Worker)? Yes | No

Sexual Orientation? Straight/Heterosexual | Lesbian or Gay | Bisexual | Something Else | Don't Know | Choose not to disclose

Gender Identity? Male | Female | Transgender/Female-to-Male | Transgender/Male-to-Female | Something else | Choose not to disclose

Acknowledgements

1) I voluntarily consent to receiving services at Christ Community Health Services Augusta (CCHSA). I give permission to all CCHSA Providers to use diagnostic and treatment procedures they deem necessary for proper medical/dental management and treatment.
2) I assign the payment of claims on my behalf to CCHSA. I understand some of the services I receive may not be covered by my third-party payor (Medicare, Medicaid, other insurance), and I am responsible for paying these amounts.
3) I understand payment in full is expected before I receive services at CCHSA. This includes payment of all service fees, copays, and/or coinsurance amounts as discounted based on my fee discount eligibility.
4) I understand CCHSA will not write prescriptions for narcotics at a patient's first appointment. I further understand CCHSA Providers do not guarantee that they will continue a narcotic prescription.
5) I understand CCHSA may discharge me as a patient for cause, or if I do not see a Provider at CCHSA in a 3 year time period.

I affirm all information provided in this Patient Information form is true and accurate to the best of my knowledge.

_____ _____ _____

SIGNATURE of Patient or Patient's Parent/Guardian | PRINTED NAME of Patient or Patient's Parent/Guardian | DATE

Protection of Health Information – For Adults

Patient Name	Last	First	Middle Initial	Date of Birth

Christ Community Health Services Augusta (CCHSA) is allowed to share the Patient's Protected Health Information (PHI) with only the people you list below. This PHI includes but is not limited to the Patient's health history, list of medicines, and lab results. These people will also be allowed to pick up the Patient's prescriptions.

AUTHORIZED ACCESS TO PATIENT'S PHI

Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	May we leave a message on this person's phone?
				Yes | No
				Yes | No
				Yes | No
				Yes | No

EMERGENCY CONTACT

Listing someone here gives permission to access the patient's PHI ONLY as necessary in the case of an emergency.

Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	May we leave a message on this person's phone?
				Yes | No

CCHSA uses Health Information Exchanges (HIEs) to share PHI with other doctors' offices, hospitals, pharmacies, etc. HIEs make it easier and faster for all your healthcare providers to have access to your health information so they can give you the best care possible. Only Network Participants of HIEs who are relevant to a patient's care are allowed to share and view patients' PHI through HIEs.

You have the right to ask that we do not share your PHI through HIEs. Whether you participate will not affect your access to services at CCHSA. If you do not want your PHI to be shared through HIEs, please check this box.

☐ Opt Out

Acknowledgements

1) I have been given the chance to review the Notice of Privacy Practices.
2) I give permission for CCHSA to use and to share the Patient's PHI with necessary third-parties for payment, for treatment, and for general healthcare operations.
3) I give permission for CCHSA to share the Patient's PHI and to release the Patient's prescriptions to each of the people listed in the AUTHORIZED ACCESS TO PHI table above. I have the legal right to give this authority to the people listed on this form.
4) I understand that I have the right to restrict how CCHSA shares PHI and I can cancel this permission any time.

_____ _____ _____

SIGNATURE of Patient or Patient's Representative PRINTED NAME of Patient or Patient's Representative DATE

CHRIST COMMUNITY HEALTH

For God so loved the world that he gave his one and only Son, that **whoever** believes in him shall not perish but have eternal life.

John 3:16

APPLICATION FOR FEE DISCOUNTS

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____ ACCOUNT NUMBER: _____

LIST SPOUSE AND DEPENDENT CHILDREN UNDER 18, AS CLAIMED ON TAXES, LIVING IN THE HOUSEHOLD AND THEIR DATES OF BIRTH

NAME	RELATION TO PATIENT	DATE OF BIRTH	GROSS MONTHLY INCOME
	SELF		

1. IF NO INCOME FROM A JOB, HOW ARE YOU SUPPORTED? _____
2. DO YOU HAVE HEALTH INSURANCE? ☐ NO ☐ YES
3. ARE YOU/ YOUR SPOUSE OFFERED HEALTH INSURANCE THROUGH AN EMPLOYER? ☐ NO ☐ YES
4. DO YOU HAVE MEDICAID IN GA OR SC, OR HAVE HAD MEDICAID IN ANOTHER STATE? ☐ NO ☐ YES
5. DOES ANYONE IN YOUR HOUSEHOLD HAVE A PENDING AUTO, WORKER'S COMP, OR OTHER PERSONAL INJURY CLAIM? ☐ NO ☐ YES
6. HAVE YOU/ YOUR SPOUSE LOST: JOB, INCOME, HEALTH INSURANCE, MOVED, MARRIED/DIVORCED IN THE LAST 60 DAYS? ☐ NO ☐ YES
7. DOES ANYONE IN YOUR HOUSEHOLD CURRENTLY NEED WIC? ☐ NO ☐ YES

You will need to provide verification of income for each household member- Mark ALL that apply

☐ EMPLOYMENT = **(4)** WEEKLY, (**2**) BIWEEKLY, (**1**) MONTHLY PAYSTUBS, LETTER FROM EMPLOYER WITH CONTACT INFORMATION

☐ UNEMPLOYMENT /WORKER'S COMP =BENEFIT LETTER
☐ SOCIAL SECURIT/ SSI = BENEFIT LETTER

☐ PENSION, DISABILITY, VA BENEFIT= BENEFIT LETTER

☐ ODD JOBS = SELF EMPLOYMENT DECLARATION FORM
SUPPORT FAM/FRIENDS- LETTER OF SUPPORT

☐ SELF EMPLOYMENT = COMPLETE TAX FORMS INCLUDING SCHEDULE C

☐ CHILD SUPPORT = INVOLUNTARY/VOLUNTARY = COURT ORDER OR LETTER FROM ABSENT PARENT

☐ ALIMONY = COURT ORDER OR LETTER FROM SPOUSE

☐ OTHER= PROOF OF ANY OTHER INCOME SUCH AS DIVIDENDS, INTEREST, RENTAL INCOME

☐ NO INCOME/ LIVING OFF OF SAVINGS = MOST RECENT BANK STATEMENT WITHIN 30 DAYS PRIOR TO APPLICATION

I have read and understand the "Fee Discounts Overview" and agree to follow its guidelines. I understand that I must provide the necessary proof of income documents to qualify for fee discounts. I will notify Christ Community Health Services as soon as possible if the size or income of my Household/Family changes. Based on the information shared in this application and the assessment made by CCHSA staff**, I agree to pay the discounted fee required of me for each visit.** I understand that the fee I have to pay may be different depending on the type of services I am receiving. I understand I may be required to pay additional fees for certain laboratory testing, supplies/equipment, or for dental services not considered "basic", and that these amounts will be discussed with me prior to receiving services. I affirm all information provided in this Application for Fee Discounts is true and accurate to the best of my knowledge. I give appropriate CCHSA staff permission to investigate any information provided in this application. I understand providing false information will result in no longer being eligible for fee discounts. **I also understand, once approved for the Fee Discount Program, I will receive a discount for dates of services to only include 30 days prior to the date of this application. I also understand that my eligibility will extend from the date of my signed application forward one year.**

_____ _____

SIGNATURE DATE

For Office Use Only:

ANNUAL INCOME: _____

HOUSEHOLD SIZE: _____

PROCESSED BY: _____ DATE: _____

COMMENTS:

No-Show Policy Acknowledgement

Your healthcare providers want to make sure that you and other area residents have access to high quality medical and dental care when you need it. To ensure maximum access to care for all of our patients, please be aware of and follow the Appointment/No-Show Policy.

Keeping Scheduled Appointments & Arriving Early

We will do our best to remind you of your upcoming medical or dental appointment by phone, mail, or email. But it is *your responsibility to remember your appointment date and time*.

You are required to arrive 20-30 minutes *before* your scheduled appointment time. If you cannot make it or think you will be late to your scheduled appointment, please let us know *as soon as possible*. If you are more than 5 minutes late, we might require you to be re-scheduled. If you are having a hard time finding transportation, please let us know. We might be able to connect you to resources that can help.

What is considered a "No-Show"?

- A no-show is someone who does not arrive for their appointment on the day of the appointment.

What happens when I "No-Show" my appointment?

When you don't come to your appointment, you take an appointment time away from someone else who could have used it. **Because there are so many people in our community who do not have access to quality medical and dental services, *"No-Shows" are taken very seriously*.**

New Patients:
If you No-Show your first medical appointment, you will be allowed once chance to re-schedule it for another time. If you do not come to your second New Patient appointment, you will not be able to make a new patient appointment for one (1) year.
If you No-Show your first dental appointment, you will not be allowed to schedule future appointments. You may be placed on the "Same Day" appointment list at the discretion of appropriate dental staff.

Established Patients:
If you no show your appointments, your medical and dental provider may allow you to still make appointments. These appointments will be "Same Day" appointments. This means you will not be allowed to schedule appointments ahead of time but must call in the same day you want to be seen. You will be added to the schedule if there are Same Day appointments available for that day. If you show that you can keep appointments regularly, you may be allowed to make regular appointments again.

Patients under age 18 may be granted an exception to the No-Show Policy at the discretion of a medical or dental provider.

I understand and agree to abide by this No-Show Policy.

_____ _____

Patient or Patient's Parent/Guardian Signature Date

Revised 12/2018