Patient Information

CHRIST COMMUNITY Pediatrics

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) May we send a text message? (circle one)	Yes | No 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 | Black or African American | White | More than one race
Asian Indian | Chinese | Filipino | Japanese | Korean | Vietnamese | Other Asian
Native Hawaiian | Guamanian or Chamorro | Samoan | Other Pacific Islander

Ethnicity? Mexican, Mexican American, Chicano/a | Puerto Rican | Cuban | Other Hispanic, Latino/a | Not Hispanic, Latino/a

Are you a veteran? Yes | No **Primary Language?** English | Spanish | Other _____ Need interpretation services? 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 | Other | Don't Know | Choose not to disclose

Gender Identity? Male | Female | Transgender/Female-to-Male | Transgender/Male-to-Female | Other | 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 Staff to use diagnostic and procedures they deem necessary for proper medical, dental, behavioral and spiritual care.
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 period.
6) I understand Christ Community is an integrated care system, meaning that all providers work together to coordinate my care. I understand all my visit notes are part of my medical record. This means that other providers at Christ Community who care for me may have access to this information.
7) Some services at Christ Community Health may include the use of telemedicine equipment and interaction with providers who are not physically onsite. These services are conducted via secure lines and are not videotaped, routed through the internet, or saved in any means.

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 Minors

Patient Name	Last	First	Middle Initial	Date of Birth

If the patient is an emancipated minor, please tell CCHSA Staff and complete the Adult PHI Form.

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.

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

☐ IF SOMEONE OTHER THAN A PARENT/LEGAL GUARDIAN WILL BRING YOUR CHILD TO APPOINTMENTS, call about your child's health, and/or PICK UP PRESCRIPTIONS for your child, check this box.
(Please complete the Consent by Proxy form)

EMERGENCY CONTACT (other than a parent or legal guardian) *Listing someone here does not give them permission to bring your child to appointments or to pick up prescriptions, etc.*				May we leave a message on this person's phone?
Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	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

CCHSA uses automated transcribing technology designed for healthcare professionals to document your encounters accurately and efficiently. This helps your provider organize your healthcare information more efficiently and give you the best care possible. If you do not want us to use this tool, 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 parents/legal guardians listed above. I have the legal right to give this authority.
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's Parent or Legal Guardian	PRINTED NAME of Parent or Legal Guardian(s)	DATE

No-Show Policy Acknowledgement
Pediatric Medical and Behavioral Health

Your healthcare providers want to make sure that yours and other area children have access to high quality care when they 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 child's upcoming appointment by phone, mail, or email. But it is *your responsibility to remember the 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 a scheduled appointment, please let us know *as soon as possible*. Notification after 3:00 pm the business day before the appointment is too late and is considered a no-show. If you are more than 15 minutes late, we might require you to re-schedule.

What is considered a "No-Show"?

- A no-show is someone who does not arrive for their appointment on the day of the appointment or does not notify the office before 3:00 pm the business day before 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 services, *"No-Shows" are taken very seriously*.**

<u>New Patients</u>:
If you No-Show two appointments to establish care, you will not be allowed to schedule another appointment for one year.

<u>Established Patients</u>:
If you No-Show three appointments in a six-month period, you may not be allowed to schedule another appointment for one year but must call for a same-day appointment if any are available.

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

_____ _____

Patient or Patient's Parent/Guardian Signature Date

Child Immunization Policy Form

As part of Christ Community Health's commitment to providing the best care for your child, we require compliance with the recommended childhood vaccination schedule.

Please review the following immunization requirements and sign to acknowledge your understanding and agreement. Children who are not fully immunized by their second birthday must be scheduled to return for catch-up vaccinations.

Compliance with Full Vaccination by Age 2

To ensure your child's health and well-being, we require that childhood vaccines be up to date by age 24 months. Per vaccination standards, Vaccine Information Sheets (VIS) will be given to you prior to the administration of any vaccine. The required vaccinations include:

- **DTaP – Four doses**
- **IPV – Three doses**
- **Hib – Three or four doses (depending on the brand)**
- **Hep B – Three doses**
- **Varicella – One dose**
- **MMR – One dose**
- **Hep A – One or two doses**
- **PCV – Four doses**

Children Who Join After Age 24 Months

Children who establish care with Christ Community Health after the age of 24 months must be up to date on vaccinations or schedule appointments to catch up on any late or delayed immunizations.

Policy Compliance

Compliance with Christ Community Health's Childhood Vaccination Policy is necessary for your child to continue receiving care at our clinic.

I understand and agree to abide by this Child Immunization Policy.

_____ _____

Patient or Patient's Parent/Guardian Signature Date

Revised 03/2025