Asher Community Health Center

Patient Registration Form

Patient Information

Last Name:	First Name:	Middle Name:	
Social Security Number:	Date of Birth:	Gender: Male / Female	
Street Address: P.O. Box:	City:	State:	Zip:
Telephone (Home):	Marital Status: Single / Married / Partnered / Separated / Divorced / Widowed		
Telephone (Work):	Name of Spouse/Partner:		
Mobile:	Driver's License (Issuing State/Number):		
Email :	Contact By: Phone / Mail / Do Not Contact		
Primary Language:	Interpreter Needed: Yes / No	What Language:	
Race: Asian / Alaskan Native / American Indian / Black / Native Hawaiian / Pacific Islander / White / Not Collected / Unknown			
Ethnic Group: Hispanic / Non-Hispanic / Not Collected / Unknown	Are you a Veteran?		
Student Status: Full-time / Part-time / NA	Employment Status: Full-time / Part-time / Self / Retired / Active Military / None		
Employer Name:	Occupation:		
Address:	City:	State:	Zip:
Employer Telephone:	Date of Employment:		
Are You an Agricultural Worker? Yes / No	If Yes: Seasonal / Migrant		
Family Size:	Total Annual Household Income:		
Do You Consider Yourself Homeless (circle one): Living in a Shelter or Gospel Mission / Street, Camp, or Bridge / At Risk for Homeless / Transitional			
Living with others (more than one family per home) / Current not Homeless, was in the Last 12 Months			
Primary Care Provider:			
Circle all that apply: Air Link Membership Life Flight Membership None			

Responsible Party Information

□ Same as Above	Patient's Relationship to Responsible Party: Self / Spouse / Partner / Child / Guardian		
Last Name:	First Name:	Middle Name:	
Social Security Number:	Date of Birth:	Gender: Male / Female	
Address:	City:	State:	Zip:
Telephone (Home):	Marital Status: Single / Married / Partnered / Separated / Divorced / Widowed		
Telephone (Work):	Name of Spouse/Partner:		
Driver's License (Issuing State/Number):	Contact By: Phone / Mail / Do Not Contact		
Primary Language:	Interpreter Needed: Yes / No	What Language:	
Employment Status: Full-time / Part-time / Self / Retired / Active Military / None			
Employer Name:	Occupation:		
Address:	City:	State:	Zip:
Employer Telephone:	Date of Employment:		
Family Size:	Total Annual Household Income:		

Emergency Contact Information

1st Contact Name:		Spouse / Partner / Parent / Child / Sibling / Friend / Attorney		
Telephone (Home/Work):	Address:	City:	State:	Zip
2nd Contact Name:		Spouse / Partner / Parent / Child / Sibling / Friend / Attorney		
Telephone (Home/Work):	Address:	City:	State:	Zip

MEDICAL HISTORY:

HAVE YOU EVER HAD AN ALLERGY OR NEGATIVE REACTION TO A MEDICATION

MEDICATION:	REACTION:

Do YOU have, or have you ever had any of the following? Mark Yes or No
If so when were you diagnosed?

	YES	NO		YES	NO		YES	NO
Allergies			Anemia			Anxiety		
Arthritis			Asthma			Blood Transfusion		
Cancer			Cataracts			CHF (heart failure)		
Clotting (bleeding)			COPD			Depression		
Diabetes			Emphysema			Heart Burn		
Glaucoma			Heart Murmur			HIV/AIDS		
High Blood Pressure			Kidney Disease			Meningitis		
MI (Heart Attack)			Nerve/Muscle problem			Osteoporosis		
Seizures			Sickle Cell Anemia			Stroke		
Substance Abuse			Thyroid Disease			TB (Tuberculosis)		
Ulcers			Other			Other		

SURGICAL HISTORY:

Have YOU ever had any of the surgeries listed below? IF SO WHEN?
If you have had a procedure not listed, please note under other.

	YES	NO		YES	NO		YES	NO
Appendectomy			C-Section			Prostate Surgery		
Brain Surgery			Eye Surgery			Small Intestine		
Breast Surgery			Fracture Surgery			Spine Surgery		
CABG/heart			Hernia repair			Tubal Ligation		
Gallbladder			Hysterectomy			Valve Replacement		
Colon Surgery			Joint replacement			Vasectomy		
Cosmetic Surgery			OTHER			OTHER		

Immunizations	Date Received	Place Where Immunization Received
Tetanus		
Flu		
Shingles		
Pneumonia		
HPV		
COVID (Circle one) Moderna, Pfizer or Johnson and Johnson		
Other		

Have you had any special tests? IF SO WHEN?	**YES**	**NO**	**Date and Place Performed**
EKG			
Colonoscopy			
Echocardiogram			
Other			

FAMILY HISTORY																
	If Living		**If Deceased**		**Alcohol/drug abuse**	**Arthritis**	**asthma**	**cancer**	**Heart problems**	**Depression**	**High Cholesterol**	**High Blood P**	**Kidney Disease**	**Mental Illness**	**Stroke**	**Vision Problems**
	Age	**Health**	**Age at death**	**Cause of Death**												
Mother:																
Father:																
Siblings:																
Children:																

SOCIAL HISTORY:					Tobacco			
Do you currently or have you in the past drank alcohol?	never	current	past		Do you currently or have you in the past used tobacco?	never	current	past
Type	Amount Per Day				Type	Amount Per Day	# of years	Date quit
Glasses of wine					Cigarettes			
Cans of beer					Cigars			
Shots of Liquor					Pipe			
Drinks containing .5 oz of alcohol					Chew			
Ready to quit?					Ready to quit?	Yes or No		

Current Medications				Drug Use			
				Do you currently or have you ever used any of the following?	never	current	past
				Type	**# of Times, Each Week**		**Date Quit**
				Marijuana			
				Ecstasy			
				Meth			
				Heroin			
Sexual Health				Cocaine Crack			
Sexual Activity	Yes	No	Not currently	Pain Pills			
Last Menstrual Period	**Date:**			**Marital Status**	Single	Married	Divorced	Widowed
Birth Control	**Method:**			**Occupation**		How Long?		

Disclosure: Asher Community Health Center is a Federally Funded Health Clinic. We have many requirements that must be met to continue this funding; the government is requiring Asher Community Health Center to survey for the following questions. We thank you for your time and cooperation in helping us continue serving our communities.

You do have the right to choose to refuse to answer these questions.

Please mark any box that applies to you or the patient.

Sexual Orientation	✓
Lesbian	
Gay	
Straight (not lesbian or gay)	
Bisexual	
Something else	
Don't know	
Choose not to disclose	

Gender Identity	✓
Male	
Female	
Transgender Male to Female	
Transgender Female to Male	
Other	
Choose not to disclose	

Thank you again for your time and cooperation!!

ASHER COMMUNITY HEALTH CENTER

Serving Wheeler County and northern Lake County, OR

Fossil Clinic:
712 Jay Street

Spray Clinic:
211 Pine Street

Mitchell Clinic:
340 High Street

Christmas Valley Clinic:
87520 Bay Road
x501

NOTICE OF PRIVACY PRACTICES AGREEMENT

By signing, I agree that I have reviewed and understand the information below and that I am entitled to have a copy of Asher Community Health Center's Notice of Privacy Practices if I so choose by informing the office staff.

My health information may be created or received by Asher Community Health Center and may be in the form of written or electronic records or spoken words. My health record may also include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.
I understand that I have the right to receive and review a written description of how Asher Community Health Center will handle my health information. This written description is known as the Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Asher Community Health Center and my right regarding my health information.
I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of Asher Community Health Center's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

Patient's Printed Name _____

Patient's Signature _____ **Date** _____
Parent/legal guardian if under 15

SPECIAL PERMISSION REQUEST

By initialing I give my permission for Asher Community Health Center to leave messages on my home or mobile number: regarding appointments _____**(initial)** regarding test results_____**(initial)** Phone #:_____

I give my permission to have messages regarding treatment, billing and/or appointment status left with my spouse, partner and/or care giver as indicated below:

☐ Emergency Contact Name: _____ Phone #: _____
Relationship: _____

☐ Spouse/Partner Name:_____ Phone #: _____

☐ Other Name: _____

Relationship:_____Phone #:_____

Patient's Signature _____ **Date**_____
Parent/legal guardian if under 15

This release will be revoked only by written permission. I understand that I must send a written request to Asher Community Health Center in order to revoke this release.

Patient's Signature _____ **Date** _____
Parent/legal guardian if under 15

Notice of Privacy Practices Agreement & Special Permissions Request Reviewed: initials/date_____

Consent to Treat

Authorization/Release: I hereby authorize Asher Community Health Center to provide medical services, including surgery if necessary, either regular or emergency, as may be determined to be in the best interest of myself or patient above, for whom I am legally responsible, even if the patient is a minor.

I also agree to assign benefits to Asher Community Health Center from any policy used to reimburse charges incurred during my, or the patient's visit with Asher Community Health Center. I understand that revoking my consent will eliminate benefit payment and that I am financially responsible for all charges whether or not covered by insurance. This authorization shall remain valid until written notice is given by me.

Patient Name:_____

Signature: _____ Date: _____
(parent /legal guardian if under 15)

MRN#_____

Asher Community Health Center
Telemedicine Consent Form

Patient Name: _____

Medical Record No: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling, documentation, and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:

(a) omit specific details of my medical history/physical examination that are personally sensitive to me;

(b) ask non-medical personnel to leave the telemedicine examination room: and or

(c) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify: • That I have read or had this form read and/or had this form explained to me • That I fully understand its contents including the risks and benefits of the procedure(s). • That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Patient's/parent/guardian signature Date Time

Incoming

Asher Community Health Center

P.O. Box 307 Fossil OR 97830

Telephone: (541) 763-2725 ◆ Fax: (541) 763-2850 ◆ TTY: 1 (800) 735-2900

Authorization to Use and Release Protected Health Information

__ALL__ sections of this form __MUST__ be completed or the authorization will not be accepted.

I authorize the following facility, _____

Name of facility releasing records

Address of facility

Telephone # of facility FAX # of facility

to receive and disclose a copy of the specific health information described below regarding:

_____

Name of patient Date of birth

SEND TO: **Asher Community Health Center**
712 Jay Street
PO Box 307
Fossil, Oregon 97830

541-763-2725
Telephone # of facility

833-601-2016
FAX # of facility

The information to be released shall consist of:

( ) All health information
( ) Discharge Summary
( ) Treatment plan/progress
( ) Progress notes
( ) Medication administration
( ) Other, specify: _____
( ) Medication Orders
( ) Assessment
( ) UA results
( ) Labs
( ) Immunizations

The release is for the following:

( ) Emergency contact
( ) Disability
( ) School entry
( ) Other, specify: _____
( ) Continued care
( ) Family/friend/self
( ) Legal

The information is to be released by:

( ) All forms of communication (verbal, written, electronic, and other)
( ) Verbal only
( ) Other, specify: _____

My initials below authorize the inclusion of the following information as part of this authorized release of records:

_____HIV/AIDS information _____Mental Health information

_____Genetic testing information

_____Drug/alcohol diagnosis, treatment, or referral information

I understand I have the right to revoke this authorization, at any time, provided I do so in writing and provided it is directed to the facility responsible for completing the release of information detailed in this document. If I choose to revoke this authorization, it will no longer be used for the reasons covered by this authorization. I understand that disclosures made prior to revoking this authorization cannot be rescinded.

This authorization becomes effective on the date below, and **will expire one year from date below or the date I specify - _____.**
Specific date

I have reviewed and understand this authorization. If the information released contains alcohol and chemical dependency diagnosis and/or treatment records, the records are further protected by federal confidentiality rules (42 CFR, Part 2). The federal rules prohibit further disclosure of this information unless I expressly permit the disclosure in writing or as otherwise permitted by 42 CFR, Part 2. A general release of medical or other information is NOT sufficient. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____
Patient signature **Date**

_____
Patient representative signature **Date**

Form BC

CREDIT AND PAYMENT POLICY

We are pleased that you have chosen Asher Community Health Center as your Primary Health Care Provider. Our goal is to provide you with high quality medical care, while keeping medical costs to a minimum.

If you have insurance:
We submit claims on your behalf to your primary and secondary insurance carriers. If you have questions or concerns about your insurance coverage, please call your carrier. Your insurance contract is between you and your carrier. After your primary and secondary insurance have paid their portion, you are responsible for payment of any allowed amount that has not been paid.

Non-Covered Services:
Payment in full is required at the time of treatment for services not covered by your insurance. Co-payments are due at the time of service without exception so please be prepared to pay when you arrive for your appointment. If you are unable to pay, your appointment may be rescheduled.

Medicare:
We will submit your claim directly to Medicare and will bill your secondary insurance. After Medicare and your secondary insurance have paid their portion, you are responsible for payment of any amount that has not been paid.

Oregon Health Plan:
To receive treatment, you must currently be covered by the Oregon Health Plan and assigned to this clinic or to a Primary Care Provider at this location. You must be assigned to a health plan in which this clinic participates. Proof of coverage is required at each time of service.

Workers Compensation:
Please notify the registration desk at each appointment if your visit is due to an injury covered by Workers Compensation. To file a Worker's Compensation claim, you will need the name of your workers compensation insurance carrier, the date of your injury, the name and address of your employer at the time of the injury, and the claim number (if available). You are responsible for payment of any claim in which payment has been denied.

Motor Vehicle or Other Liability Claims:
The patient is required to provide accurate and complete billing information at the time of service when applicable.
In the event your claim is disputed or a suit is established against another party and the outstanding balance is 120 days past due, patients will be asked to work with our business office to establish a suitable payment plan to pay the outstanding charges. If a payment plan is not established, the account is subject to collection proceedings.

If you do not have insurance:
We expect self-pay (uninsured) patients to pay at time of service. Asher Community Health Center provides a sliding fee discount for those patients who qualify. In circumstances where unexpected major medical expenses are incurred, we will help you arrange a payment schedule.

Broken and Canceled Appointments:
Our clinic requests that you notify us 24 hours in advance when cancelling a scheduled appointment. We reserve the right to charge a fee for any appointment cancelled or broken without reasonable notice.

Financial Responsibility:
Patients are financially responsible for all services provided. If you are required to pay for treatment at the time of service, our staff will work with you to schedule your appointments in coordination with your financial resources. A fee will be assessed for checks returned for insufficient funds. Failure to meet financial responsibility may result in legal action.

We accept: Cash, Personal Checks, Money Orders and Most Major Credit Cards

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