

COAST COMMUNITY HEALTH center

1010 FIRST ST SE, SUITE 110

BANDON, OR 97411

541-347-2529

541-347-9196 (fax)

www.coastcommunityhealth.org

Dear Prospective Patient of Coast Community Health Center,

Our goal as a Federally Qualified Health Center is to provide exceptional medical care and serve our patients timely and efficiently. To help get us to know each of our new patients better, we have put together this new patient packet. We realize it is a lot of information, but it is very important that this packet be complete and accurate so that we can provide you with the best care possible.

We have included in this packet everything you will need to establish care at Coast Community Health Center. When you have completed the packet, please return it to our health center either by mail, or you can drop it off in person, whichever is easiest for you.

HEALTH CENTER HOURS

Monday	7:30 am – 6:00 pm
Tuesday	7:30 am – 6:00 pm
Wednesday	7:30 am – 6:00 pm
Thursday	7:30 am – 8:00 pm
Friday	7:30 am – 6:00 pm

Lab services available Monday – Friday. Ask your patient representative for available times.

After Hours services are available by calling the Health Center at 541-347-2529.

The staff and leadership of Coast Community Health Center looks forward to meeting you! Please feel free to call the health center with any questions you may have.

Best regards from all of us!

Statement of Office Policy

Patient Expectations

- Complete, Sign, Date and Return your NEW PATIENT PACKET to our office no later than three (3) business days before the initial visit. Incomplete forms may result in a rescheduled appointment
- Arrive 15 MINUTES PRIOR to your scheduled appointment. Late arrivals may result in a rescheduled appointment.
- Bring your full MEDICATION LIST (or medications) to all appointments.

Appointments

- Cancellations less than 24 hours prior to a scheduled appointment will be considered a NO SHOW APPOINTMENT. Two missed appointments will result in a letter of warning. A third missed appointment may result in a patient being dismissed.
- Walk-in availability is limited. Appointments are required. Late arrivals and incomplete forms may result in rescheduling your appointment.
- We handle long-term pain management through a system of referral to partner organizations.
- We have an on-call Provider available after hours. After hours' coverage is provided for all patients by calling the Health Center main number at 541-347-2529 after normal business hours. Your call will connect you to the Provider on-call. In an **EMERGENCY, CALL 911** or go to your closest hospital.

Prescriptions

- Patients are responsible for contacting their pharmacy and requesting that medications refills be faxed to our office. Coast Community Health Center has a 48-hour business hour refill policy. Our fax number is 541-347-9196.
- It is the responsibility of the patient to provide us with their insurance formulary list. The health center may or may not provide prior authorizations.

Messages

- By signing the Statement of Office Policy, the undersigned agrees and authorizes Coast Community Health Center to leave a voice-mail message at the phone number(s) designated by the undersigned.

Weapons in the Health Center

Coast Community Health Center strives to maintain an environment that is caring, nurturing and safe. Patients, therefore, are requested not to bring weapons of any form into the health center facilities. (The only exception is for authorized law enforcement officers while on duty.)

New Patients, Insured

- We are participating providers for most private pay insurances.
- We bill all insurance companies as a courtesy. It is the patient's responsibility to monitor the payment process with the insurance company. Although we make every effort to help patients collect from an insurance claim, the patient is responsible for the bill.
- All payments are due at the time of services rendered.
- We provide primary care services for low-income uninsured patients. Please inquire at the front desk for more information on some of our programs that could benefit you. Sliding Scale application can be found on our website at www.coastcommunityhealth.org.

Financial Policy

- Payment is due for services rendered at the time of the visit.
- Patients with household incomes below 200% of the Federal Poverty Guidelines (FPG) may qualify to have their services, deductible and/or co-payment discounted on the sliding fee scale. We offer different payment levels for Sliding Scale.
- A valid insurance card and/or ID is needed at each visit.
- We will bill your insurance as a courtesy. You will be responsible for keeping the account in good standing and also be responsible for any balances denied by insurance.
- We work with our patients regarding setting up payment terms.
- If there is an outstanding balance 90 days after the date of service, we may turn your account over to a collection agency. In the event that your account does go to an outside agency, you agree to pay any court costs and reasonable attorney's fees, with or without suit, incurred in collecting any past due balances. If a suit or an action is filed, the amount of such reasonable attorney's fees or collection charges shall be fixed by the court in which the suit or action (including any appeal therein) is tried, heard or decided.
- Personal pay patients must pay for their visit in full at time of service.
- Any payments can be made by cash, check, or credit card.
- Patients will be expected to pay a \$25.00 returned check fee for any checks that are returned.

Patients Qualifying for the Sliding Fee Scale Payment Plan

- You may qualify for the sliding fee schedule. The sliding fee scale payment plan is based on your household size and income. In order to qualify for the sliding fee scale, you must provide certain source documents regarding your income.
- Services rendered are due on the date of service. Based on the qualifications, your minimum charge will cover the estimated cost of your office visit. Other services may require additional charges.

Ask a Patient Representative for the Sliding Fee Scale packet.

1	0 - \$12,060	\$12,061 - \$15,075	\$15,076 - \$18,090	\$18,091 - \$21,105	\$21,106 - \$24,120
2	0 - \$16,240	\$16,241 - \$20,300	\$20,301 - \$24,360	\$24,461 - \$28,420	\$28,421 - \$32,480
3	0 - \$20,420	\$20,241 - \$25,525	\$25,526 - \$30,630	\$30,631 - \$35,735	\$35,736 - \$40,840
4	0 - \$24,600	\$24,601 - \$30,750	\$30,751 - \$36,900	\$36,901 - \$43,050	\$43,051 - \$49,200
5	0 - \$28,780	\$28,781 - \$35,975	\$35,976 - \$43,170	\$43,171 - \$50,365	\$50,366 - \$57,560
6	0 - \$32,960	\$32,961 - \$41,200	\$41,201 - \$49,440	\$49,441 - \$57,680	\$57,681 - \$65,920
7	0 - \$37,140	\$37,141 - \$46,425	\$46,426 - \$55,710	\$55,711 - \$64,995	\$64,996 - \$74,280
8	0 - \$41,320	\$41,321 - \$51,650	\$51,651 - \$61,980	\$61,981 - \$72,310	\$72,311 - \$82,640
9 or more	Write in pre-tax income \$				

We appreciate your interest in becoming a patient of Coast Community Health Center. Please sign and return this form to acknowledge you have read and understand our Statement of Office Policy.

Patient Name (Please Print)

Signature

Date

Patient Representative (Please Print)

Signature

Date

Relationship to Patient

Coast Community Health Center 1010 First Street SE, Suite 110, Bandon, OR. 97411 541-347-2529

www.coastcommunityhealth.org

PATIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married(partner) ☐ Widowed ☐ Divorced(separated)

Sex: ☐ Male ☐ Female ☐ Transgender

Email address (required): _____

This will grant you access to our Patient Portal. (If you would like to opt out at any time, please notify a Patient Representative)

How would you like us to contact you about your appointments? (more than 1 can be selected)

☐ Phone ☐ Home ☐ Cell ☐ Work

☐ Text Message

☐ e-mail (email address has to be provided above)

ADDRESS INFORMATION (PLEASE PRINT)

Physical: _____

Mailing: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Home Phone: _____

Cell: _____

EMPLOYER INFORMATION (PLEASE PRINT)

Employer Name: _____

Work: _____ Ext: _____

SECONDARY AUTHORIZED PARTY (PLEASE PRINT)

Spouse Name (if applicable): _____

Employer Name: _____ Phone: _____

Parent/Guardian Contact Name (if younger than 18): _____

Parent/Guardian DOB: _____ Parent/Guardian SSN: _____

EMERGENCY CONTACT INFORMATION (PLEASE PRINT)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION (PLEASE PRINT)

Primary Insurance Company: _____ Effective Date: _____

Subscriber Name (if not self): _____

Subscriber DOB: _____ Subscriber SSN: _____ ID#: _____ Group#: _____

Relationship to Patient: _____

Secondary Insurance Company: _____ Effective Date: _____

Subscriber Name (if not self): _____

Subscriber DOB: _____ Subscriber SSN: _____ ID#: _____ Group#: _____

Relationship to Patient: _____

If you do not have insurance coverage, are you applying for our Sliding Scale Program? ☐ Yes ☐ No

NEW PATIENT MEDICATION LIST

Your complete medication history is important. Patients are required to update this list for accuracy at each appointment. If for some reason you are unable to fill out this form, please bring all your medications you are taking, **in their original containers**, to your first appointment.

Allergies: Are you allergic to medications, iodine, shellfish, food, tape, or latex?

List each substance and your reaction.

ALLERGY	REACTION	ALLERGY	REACTION
<input type="checkbox"/> No know allergies			

Current Medications: List all prescription, non-prescription, and over-the-counter medications that you use including, herbals, eye drops, nutritional supplement(s), inhalers, etc. List any medication being held prior to a scheduled surgery, and any medication that you have recently completed (including antibiotics).

State Date	Medication	Amount & Dose	Route (Ex. mouth, spray)	Directions (Ex. 2 times/day)	Purpose

Pharmacy Name: _____

Pharmacy Phone: _____

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CLINICAL HISTORY AND PHYSICAL FORM

Patient Information

Name: _____ Age: _____ DOB: _____

Previous Family Physician: _____

Referring Physician: _____

Reason for Visit: _____

Past Medical History:

(Please circle all that apply):

None	Coronary Artery Disease	Hepatitis A B or C	Osteoporosis
Allergy: Food	Depression	High BP	Seizure
Allergy: Seasonal	Diabetes-Diet Controlled	High Cholesterol	Sleep Apnea
Anxiety	Diabetes-On Insulin	HIV	Stroke/TIA
Arthritis (type): _____	Diabetes-Oral Meds	Hyperthyroid	TB
Asthma	Emphysema	Hypothyroid	
Bleeding Difficulties	Heart Disease	Loss of Consciousness	

Cancer: Type/Treatment: _____

Other: _____

Past Surgical History

(Type of Surgery & Year)

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Social History

Tobacco Use

☐ Never
☐ Quit
When? _____
☐ Cigarettes
Pack per day _____
☐ Pipe
☐ Cigar
☐ Chewing Tobacco
Years? _____

Alcohol Use

☐ None
☐ Socially
☐ Daily
☐ Heavy
Have you ever
been treated
for alcoholism?
☐ No ☐ Yes

Drug Use

☐ None
☐ Marijuana
☐ Amphetamines
☐ Other _____
Have you ever
been treated for
drug use?
☐ No ☐ Yes

Exercise

☐ None
☐ 1-2x/week
☐ 3-4x/week
☐ 5-6x/week
Type: _____

Caffeine Use

☐ None
☐ Occasional
☐ Daily
How much?

Are there any religious beliefs that would affect your medical care? _____

Education

Please check the highest level: ☐ Grade School ☐ High School ☐ College ☐ Post Graduate

Patient Name _____

Date of Birth _____

Occupational History

Have you altered your job as a result of the problem you brought here today? ☐ Yes ☐ No

If yes, please explain: _____

If you're currently off work as a result of the problem, how long have you been off? _____

Family History

Father Age: ____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Medical History or Cause of Death: _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type: _____ <input type="checkbox"/> Other: _____
Mother Age: ____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Medical History or Cause of Death: _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type: _____ <input type="checkbox"/> Other: _____
Brothers Age: ____	# Living _____ # Deceased _____	Medical History or Cause of Death: _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type: _____ <input type="checkbox"/> Other: _____
Sisters Age: ____	# Living _____ # Deceased _____	Medical History or Cause of Death: _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type: _____ <input type="checkbox"/> Other: _____
Children Age: ____ Age: ____	# Living _____ # Deceased _____	Medical History or Cause of Death: _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type: _____ <input type="checkbox"/> Other: _____

For Females:

Are you pregnant? _____ Are you breast feeding? _____ # of Pregnancies/Deliveries _____

Date of first menstrual period? _____ Date of last menstrual period? _____

Last Mammogram: _____ Last Pap: _____ Last Bone Density Scan? _____

For Males:

Do you experience impotency? _____

Immunizations:

Flu Date: _____ Pneumonia Date: _____ Colonoscopy Date: _____ Tetanus Date: _____

Vaccines: Check one box for each vaccine

TETANUS	PNEUMOCOCCAL	INFLUENZA	PEDIATRIC (child only)
<input type="checkbox"/> Within past 10 years	<input type="checkbox"/> Within past 5 years	<input type="checkbox"/> Within past year	<input type="checkbox"/> Up-to-date
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never

Other Screenings: _____

ACKNOWLEDGEMENT AND CONSENT

Patient Name

Date of Birth

I understand that my health information may include information both created and received by Coast Community Health Center (CCHC), that it may be in the form of written or electronic records or spoken words, and may include information about my health and mental health history, health status, symptoms, examinations, tests results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that CCHC may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment (including activities performed by physician, nurse practitioner or other healthcare providers directly delivering care at CCHC);
- Refer to consult with, coordinate among, and manage along with other healthcare providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related health information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative and business functions that support my Provider's efforts to provide me with, arrange, and be reimbursed for quality, cost effective healthcare.

I also understand that I have the right to receive and review a written description of how the health center will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made, the information practices followed by the employees, staff, and other office personnel of CCHC, and my rights 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 the most current version of the Coast Community Health Center Notice of Privacy Practices or a summary in effect will be posted in the waiting/reception area and that a copy is available upon request.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that CCHC is not required by law to agree to such requests.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that CCHC is not required by law to agree to such requests.

I hereby give permission to disclose and release information to the following persons for the specific purpose of managing my healthcare.

Name (please print)

Relationship (please print)

Phone Number

Name (please print)

Relationship (please print)

Phone Number

By signing below, I agree that I have received, reviewed and understand the information above. I understand I have the right to revoke this CONSENT and provided that I do so in writing, except to the extent that has already been used or information disclosed in reliance on this consent.

Patient Name (please print)

Signature

Today's date

Patient Representative (please print)

Signature

Today's date

Relationship to Patient (please print)

Authorization for Release of Health Information

I authorize _____
Name of Medical Office/Provider

Address/PO Box City State Zip

Telephone: _____ Fax: _____

to release a copy of my health information described below regarding:

Name of patient

Date of Birth: _____ Social Security Number: _____

for the purpose of: _____

To: Coast Community Health Center Address: 1010 First St SE, Ste. 110, Bandon, OR 97411
Telephone No: 541-347-2529 Fax No: 541-347-9196

By initialing below, I specifically authorize the release of the following records, if such records exist: _____

patient initial

History & Physical	Medications (all)	Diagnostic Tests (last 5 years)
Chart Notes (last 1 year)	Diagnoses (all)	Operative Reports (last 5 years)
Labs (last 2 years)	Mammogram (last available)	Radiology (last 5 years)
Immunizations (all)	Pap Smear (last available)	Consultation Reports (last 5 years)
Food/Drug Allergies (all)	Colonoscopy (last available)	Pathology Reports (last 5 years)

Other/specific records: _____

If the information contains any of the type of records or information listed below, additional laws relating to use the disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

HIV/AIDS: _____ **Mental Health:** _____ **Genetic Testing:** _____

Alcohol/drug diagnoses, treatment, referral: _____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient and no longer be protected under federal law. Unless revoked earlier, this authorization shall remain in effect for 1 year of signing this authorization. I understand I can cancel this authorization at any time by sending a letter to Coast Community Health Center. The cancellation will not affect any information that was already disclosed.

I also understand there may be a charge of no more than \$30 for copying 10 or fewer pages, and no more than 50 cents per page from pages 11 through 50, and no more than 25 cents for each additional page; A charge of \$5 if the request for records is processed and mailed by first class mail to the requester. You may apply for a hardship if you have been approved for our sliding scale fee payment.

A patient may not be denied copies of his/her medical records because of inability to pay.

Patients Signature Today's date

Other Authorized Person (print name) Relationship to Patient Other Authorized Person(signature)

Patient Name

Date of Birth

The information you share with us below, allows us to received continued support through the Bureau of Primary Health Care as a Federal Qualified Health Center. Your cooperation is greatly appreciated and your answers will be held in strictest confidence.

**Gender at Birth
(circle one)**

Male

Female

**Sexual Orientation:
(circle one)**

Lesbian or Gay

Straight (not lesbian or gay)

Bisexual

Something else

Don't know

Choose not to disclose

**Gender Identity:
(circle one)**

Male

Female

Transgender Male/Female-to Male

Transgender Female/Male to Female

Other

Choose not to disclose

1. Would it be convenient to have a translator for your visit? ☐ Yes ☐ No

What language? _____

2. What is your current housing status? (Where did you spend last night?)

☐ Permanent Housing/Not Homeless (Own/Rent) ☐ Homeless Shelter

☐ Public Housing

☐ Doubling Up (live with another family in same household) ☐ Street

☐ Temporary Situation/Transitional

3. What is your work condition?

☐ Full Time Employment (ALL year, full or part time)

☐ Disabled

☐ Retired

☐ Seasonal Worker (works only certain seasons, not all year)

☐ Student

☐ Not working

4. If you are under 18 years of age, are either of your parents: ☐ Seasonal ☐ N/A

5. What is your race? (Select all that apply)

☐ American Indian or Alaska Native

☐ Native Hawaiian

☐ White

☐ Asian

☐ Other Pacific Islander

☐ Unreported/Refused to Report

☐ Black or African American

☐ Other: _____

6. Are you Latino or Hispanic Ethnicity? ☐ Yes ☐ No

7. Are you a veteran? ☐ Yes ☐ No

Instructions for grid below:

1. Circle your household size in column one.

2. Then circle your household's approximate pre-tax annual income in that row.

1	0 - \$12,060	\$12,061 - \$15,075	\$15,076 - \$18,090	\$18,091 - \$21,105	\$21,106 - \$24,120
2	0 - \$16,240	\$16,241 - \$20,300	\$20,301 - \$24,360	\$24,461 - \$28,420	\$28,421 - \$32,480
3	0 - \$20,420	\$20,241 - \$25,525	\$25,526 - \$30,630	\$30,631 - \$35,735	\$35,736 - \$40,840
4	0 - \$24,600	\$24,601 - \$30,750	\$30,751 - \$36,900	\$36,901 - \$43,050	\$43,051 - \$49,200
5	0 - \$28,780	\$28,781 - \$35,975	\$35,976 - \$43,170	\$43,171 - \$50,365	\$50,366 - \$57,560
6	0 - \$32,960	\$32,961 - \$41,200	\$41,201 - \$49,440	\$49,441 - \$57,680	\$57,681 - \$65,920
7	0 - \$37,140	\$37,141 - \$46,425	\$46,426 - \$55,710	\$55,711 - \$64,995	\$64,996 - \$74,280
8	0 - \$41,320	\$41,321 - \$51,650	\$51,651 - \$61,980	\$61,981 - \$72,310	\$72,311 - \$82,640
9 or more	Write in pre-tax income \$				