COAST COMMUNITY
HEALTH
center

1010 FIRST ST SE, SUITE 110
BANDON, OR 97411
541-347-2529
541-347-9196 (fax)
www.coastcommunityhealth.org

Our goal as a Federally Qualified Health Center is to provide exceptional medical care in a timely, efficient and professional manner. To help us to get to know you or your child better, we have put together this new patient packet. It is a lot of information, but it is important that this packet be complete and accurate so that we can provide you or your child with the best care possible.

Everything is included in this packet that you will need to establish care at Coast Community Health Center. Please return the completed packet to our health center either by mail, or drop it off in person.

HEALTH CENTER HOURS

Monday - Thursday 8 am – 7:00 pm
Friday 8 am – 6 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 and your family! 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. We may need to reschedule your appointment if we do not receive it on time.
- Please arrive 15 MINUTES PRIOR to your scheduled appointment. While we try to accommodate all patients, you may have to wait if you are late or we may need to reschedule your appointment.
- Bring your full MEDICATION LIST (or medications) to all appointments.

Appointments

- It is important to contact us if you are unable to keep your appointment. Your time and our time is valuable. The sooner you let us know that you cannot make your appointment, the sooner we can schedule someone else who needs medical care.
- Walk-in availability is limited. While we will try to accommodate you, please note that you may have to wait.
- We do not manage long-term pain management. If you have long term pain then we will refer you 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 our Nurse Triage Line who can contact 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 two-business day refill policy. Our fax number is 541-347-9196.
- We will try to provide you with medications covered by your insurance; however, please provide us with your insurance company's formulary list. We will assist you in obtaining your prescription through all reasonable and appropriate means.

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.)

Financial Policy

- 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.
- 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. Please ask us for our Sliding Scale application or review it on our website at www.coastcommunityhealth.org.
- A valid insurance card and/or ID is requested at each visit.
- 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. If 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

PATIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First Name:_____ MI:____

Social Security Number:_____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

Sex: ☐ Male ☐ Female ☐ Transgender

Email address (required to access patient portal): _____

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)

☐ Home Phone ☐ Cell ☐ Work

☐ Text Message ☐ e-mail (email address must 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/Partner Name (if applicable): _____

Employer Name: _____ Phone: _____

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
☐ No known 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).

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

Pharmacy Name: _____

Pharmacy Phone: _____

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, 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.

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_____ _____ _____

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)

_____ _____

Patient Name Date of Birth

The information you share with us below, allows us to receive 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)	**Sexual Orientation: (circle one)**	**Gender Identity: (circle one)**
Male	Lesbian or Gay	Male
Female	Straight (not lesbian or gay)	Female
	Bisexual	Transgender Male/Female-to Male
	Something else	Transgender Female/Male to Female
	Don't know	Other
	Choose not to disclose	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
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