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 - Friday 8 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 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 book 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

CLINICAL HISTORY AND PHYSICAL FORM

Patient Information

Name: _____ Age: _____ DOB: _____

Previous Provider: _____

Referring Provider (if applicable): _____

Reason for Visit: _____

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 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: _____

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	Stoke/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	Alcohol Use	Drug Use	Exercise	Caffeine Use
☐ Never	☐ None	☐ None	☐ None	☐ None
☐ Quit	☐ Socially	☐ Marijuana	☐ 1-2x/week	☐ Occasional
When? _____	☐ Daily	☐ Amphetamines	☐ 3-4x/week	☐ Daily
☐ Cigarettes	☐ Heavy	☐ Other _____	☐ 5-6x/week	How much?
Pack per day ____	Have you ever	Have you ever	Type: _____	_____
☐ Pipe	been treated	been treated for	_____	_____
☐ Cigar	for alcoholism?	drug use?	_____	_____
☐ Chewing Tobacco	☐ No ☐ Yes	☐ No ☐ Yes		
Years? _____				

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

Education

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

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: ____	☐ Living ☐ Deceased	Medical History or Cause of Death: _____	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type: _____ ☐ Other: _____
Mother Age: ____	☐ Living ☐ Deceased	Medical History or Cause of Death: _____	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type: _____ ☐ Other: _____
Brothers Age: ____	# Living _____ # Deceased _____	Medical History or Cause of Death: _____	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type: _____ ☐ Other: _____
Sisters Age: ____	# Living _____ # Deceased _____	Medical History or Cause of Death: _____	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type: _____ ☐ Other: _____
Children Age: ____ Age: ____	# Living _____ # Deceased _____	Medical History or Cause of Death: _____	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type: _____ ☐ 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)
☐ Within past 10 years ☐ Unknown ☐ Never	☐ Within past 5 years ☐ Unknown ☐ Never	☐ Within past year ☐ Unknown ☐ Never	☐ Up-to-date ☐ Unknown ☐ 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. Coast Community Health Center cannot condition treatment or eligibility of benefits on whether the authorization is signed.
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 age from pages 11 through 50, and no more than 25 cents for each additional pages; 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 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
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 $				