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.

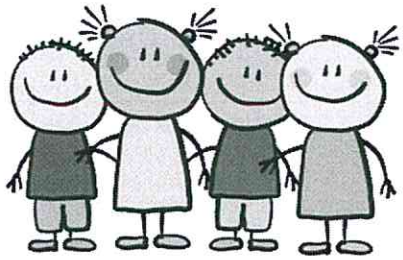
Please return the completed packet to our health center either by mail or drop it off in person.

HEALTH CENTER HOURS

Monday - Thursday 8 am – 7 pm
Friday 8 am – 6 pm
Saturday 9 am – 3 pm

Lab services available Monday – Friday. Ask the patient service 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 at 541-347-2529 with any questions you may have.



Best regards from all of us!

PATIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First Name: _____ MI:_____

Social Security Number: _____ Date of Birth: _____

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

Home Phone ____ Cell _____ Parent/Guardian Work Phone_____

Text Message ____ e-mail _____

Pharmacy Name and Phone Number:_____

ADDRESS INFORMATION (PLEASE PRINT)

Physical: _____ Mailing: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

EMPLOYER INFORMATION (PLEASE PRINT)

Employer Name: _____

Work: _____ Ext: _____

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

Immunizations:

Please bring a copy of your child's immunization record.

Ages 0-12 *Revised 8/1/18*

Say "hello" to Healow!

We are proud to inform you that Coast Community Health Center now offers the opportunity to use the power of the web to track the most important aspects of your child's healthcare through Healow, our online patient portal.

Healow enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

Participating parents are given secure User IDs and passwords, enabling you to access Healow to view your child's personal and private documents, including lab and diagnostic test results, educational information, immunization records, and other health information.

With Healow, you can:


Keep track of appointments


Review labs and diagnostics once signed off by the provider


Ask questions of doctors, nurses, and staff members


Review your referrals


View your child's personal health record


Receive health reminders


Receive educational materials


Update your demographic information

In order to protect the privacy of your child's health care information, parents may access their child's Healow account through age 12. At the age of 12, your child's account will be disabled until they turn 18.

By providing the information below, you will gain access to your child's Healow account. This access will be valid until your child turns 13 or you choose to revoke this agreement. If you have questions or need help with your Healow account, call us at (541) 347-2529.

Email address: _____

Printed name: _____

Signature: _____ Date: _____

For information about how to keep your child's personal health care information safe, please review our practice consent form on the back of this page.

COAST COMMUNITY HEALTH center

Healow/Patient Portal

PROXY Authorization

Completing this form will allow someone else to have access to your Patient Portal records.

The accuracy of this information helps to make sure the correct person is provided with authorization to access your CCHC Patient Portal.

Please PRINT as clearly as possible.

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL:_____

Date of Birth:___/___/_____

ACCESS by PROXY Information

(Proxy is the person authorized to access your healthcare information)

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL:_____

Date of Birth:___/___/_____ Gender: ☐ Male ☐ Female Phone:(___)_____

Mailing Address:_____ City:_____ State:____ Zip:_____

Email: _____

ADULT

Access to another adult's electronic health record.

☐ This section also applies to emancipated minors. Copy of proof of emancipation must be attached.

☐ **Adult-capable Adult**	☐ **Guardian of Adult**
The patient must sign this form to provide authorization for release of their medical information. • Authorization for proxy access is valid until revoked by the patient.	Mark category of guardianship ☐ Legal Guardian, court ordered ☐ Power of Attorney for: ☐ Health care ☐ Other: _____ Copy of legal document verifying this must be attached

MINOR/CHILD

Access to a minor child's Patient Portal information.

My relationship to the child is:

☐ Parent

☐ Permanent legal guardian of the patient

(copy of Court Order appointing guardian and letter of guardianship must be attached)

13-17 Years Old

You will be authorized to full access to your child's health care information with CCHC until the child turns 18.

To be completed by the Patient	To be completed by the proxy
Who is authorizing additional access to their health care information at CCHC. (does not apply to Legal Guardian, Power of Attorney, or age 13-17)	REMINDER: Copy of any legal documents must be attached to this form when submitted for processing. **Incomplete forms will not be accepted.**

AUTHORIZATION FOR ACCESS

To my personal Patient Portal

- By signing this proxy request, I understand that I am giving my permission for CCHC to disclose my protected health information (PHI) through the Patient Portal to someone else (my proxy). Information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information.
- This proxy request is effective until my Patient Portal account is inactivated or proxy access is revoked or
  ☐ expires on:_____
- This proxy request includes records that were created or existing on or before the date this form was signed, as well as records that are created after the date this form is signed.
- I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that doing so will not have any effect on any information already released to my proxy.
- I understand that the information disclosed through this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy laws.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my Patient Portal will not be granted.

By signing below, parents acknowledge and agree:

- I have parental rights or legal guardianship rights to access this child's record.
- I have not been denied periods of physical placement with the Child and there are no court orders or restraining orders in effect limiting my access to this Child's medical records and/or information.
- Communications on behalf of the Child through the Patient Portal must be sent from the Child's record and responses will be received in the Child's records. Patient Portal email alerts will be sent to the email address entered under Parent/Legal Guardian ("proxy") information.
- For a child age 13-17, I will be granted full access to the child's Patient Portal record.
- On the Child's 18th birthday, this permission will be revoked automatically.

LEGAL GUARDIANS:

All documents, if any, I have provided in support of my request to access the patient's protected health information are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify CCHC in writing of the change in authority and the date it became effective.

Adult Patient/Legal Guardian/Parent

By signing below, I acknowledge and agree to comply with the terms and conditions on the Patient Portal terms and conditions and this document.

X_____

Patient, Parent, or Legal Guardian Signature (REQUIRED)

_____

Relationship to Patient (REQUIRED)

Date:_____

Proxy

By signing below, I acknowledge, agree and understand:

- I will comply with the Patient Portal terms and conditions
- The Patient can revoke my access to his/her Patient Portal account at any time

X_____

Proxy signature (REQUIRED)

_____

Relationship to Patient (REQUIRED)

Date:_____

HIPAA ACKNOWLEDGEMENT

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.

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
_____	_____	_____
_____	_____	_____

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
_____	_____	_____
_____	_____	_____

Parent/Guardian (please print) _____ Signature _____ Today's date _____

Relationship to Patient (please print) _____

Authorization for Release of Health Information

Patient: _____
Last First Middle Date of Birth

I specifically authorize the release of the following records, if such records exist:

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: _____

From: _____
Name of Medical Office or Provider

_____
City State Zip Code Telephone Fax

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

For the purpose of: _____

If the records contain any information of the type listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I initial 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 the recipient and no longer protected under federal law. Unless revoked earlier, this authorization shall remain in effect for 1 year of signing this authorization. I understand I can revoke 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 for records as follows: $30 for pages 1-10; 50 cents per page for pages 11-50; 25 cents for each additional page; $5 if the request for records is mailed by first class mail to the requester. A patient may not be denied copies of his/her medical records because of inability to pay.

_____ _____
Patient's Signature Date

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

_____ _____
Authorized Person Signature Date

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)
Male

Female

1. **What language do you speak at home?** _____
   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 - $12,140	$12,140 - $15,175	$15,175 - $18,210	$18,210 - $21,245	$21,245 - $24,280
2	0 - $16,460	$16,460 - $20,575	$20,575 - $24,690	$24,690 - $28,805	$28,805 - $32,920
3	0 - $20,780	$20,780 - $25,975	$25,975 - $31,170	$31,170 - $36,365	$36,365 - $41,560
4	0 - $25,100	$25,100 - $31,375	$31,375 - $37,650	$37,650 - $43,925	$43,925 - $50,200
5	0 - $29,420	$29,420 - $36,775	$36,775 - $44,130	$44,130 - $51,485	$51,485 - $58,840
6	0 - $33,740	$33,740 - $42,175	$42,175 - $50,610	$50,610 - $59,045	$59,045 - $67,480
7	0 - $38,060	$38,060 - $47,575	$47,575 - $57,090	$57,090 - $66,605	$66,605 - $76,120
8	0 - $42,380	$42,380 - $52,975	$52,975 - $63,570	$63,570 - $74,165	$74,165 - $84,760
9	0- $46,700	$46,700 - $58,375	$58,375 - $70,050	$70,050 - $81,725	$81,725 - $93,400

Patient Name and Patient Representative: _____

Financial Policy

- We are participating providers for most private pay insurances.
- We bill insurance companies as a courtesy. 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 provided. Payments can be made by cash, check, or credit card.
- 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.
- A valid insurance card and/or ID is requested at each visit.
- We work with our patients regarding setting up payment terms if unable to pay full amount.
- If there is an outstanding balance 90 day 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.
- Patients will be expected to pay a $25.00 returned check fee for any checks that are returned.

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. Please ask us for our Sliding Scale application. You can also review it on our website at www.coastcommunityhealth.org.
- To qualify for the sliding fee scale, you may need to provide certain source documents regarding your income.
- Payment for services rendered are due on the date of service. Based on the qualifications, your minimum charge will cover the services of your office visit. Other services may require additional charges.

Household size

1	0 - $12,140	$12,140 - $15,175	$15,175 - $18,210	$18,210 - $21,245	$21,245 - $24,280
2	0 - $16,460	$16,460 - $20,575	$20,575 - $24,690	$24,690 - $28,805	$28,805 - $32,920
3	0 - $20,780	$20,780 - $25,975	$25,975 - $31,170	$31,170 - $36,365	$36,365 - $41,560
4	0 - $25,100	$25,100 - $31,375	$31,375 - $37,650	$37,650 - $43,925	$43,925 - $50,200
5	0 - $29,420	$29,420 - $36,775	$36,775 - $44,130	$44,130 - $51,485	$51,485 - $58,840
6	0 - $33,740	$33,740 - $42,175	$42,175 - $50,610	$50,610 - $59,045	$59,045 - $67,480
7	0 - $38,060	$38,060 - $47,575	$47,575 - $57,090	$57,090 - $66,605	$66,605 - $76,120
8	0 - $42,380	$42,380 - $52,975	$52,975 - $63,570	$63,570 - $74,165	$74,165 - $84,760
9	0- $46,700	$46,700 - $58,375	$58,375 - $70,050	$70,050 - $81,725	$81,725 - $93,400

When you make payments for services provided, you enable us to keep our doors open. You are investing in your future and ours. We appreciate that payments be made at the time services are provided.

Please sign and return this form to acknowledge you have read and understand our Financial Policy.

_____ _____

Patient or Patient Representative Signature Date

_____

Relationship to Patient if not patient