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

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: _____

GUARANTOR INFORMATION (PLEASE PRINT)

Guarantor Name: _____DOB:_____

Address (if different):_____

Social Security Number: _____Phone Number:_____

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.

CLINICAL HISTORY FORM

Patient Name: _____ DOB: _____

Parent/Guardian_____

Your child's complete medication history is important. Patients are required to update this list for accuracy at each appointment. Please bring all medications, **in their original containers**, to your first appointment.

Allergies:

List all reactions to medications, foods, and other agents.

ALLERGY	REACTION	ALLERGY	REACTION
☐ No known allergies			

Current Medications: List all prescriptions, non-prescriptions, and over-the-counter medications including, herbals, eye drops, nutritional supplement(s), inhalers, etc.

Medication	Dose & Frequency

Past Hospitalization/Surgical History:

Date	Hospital	Reason

Immunizations:

Please list immunizations that the patient has received at other health care facilities and include your best estimate of the month and year of each immunization or provide a copy of their immunizations.

	DATE		DATE
Dtap or Tdap		Polio	
Hepatitis B		Hepatitis A	
HIB		Prevnar 13	
MMR		Varicella	
Rotavirus		Influenza	

Patient Name:_____ DOB:_____

Significant Family History:

Check any family member who has suffered or experienced any of the following conditions
M=Maternal P=Paternal

	Mother	Father	Sister(s)	Brother(s)	Child(ren)	Grandmother M	Grandmother P	Grandfather M	Grandfather P
Arthritis									
Cancer									
Cardiac Disease									
Depression									
Diabetes									
Hypertension									
Stroke/TIA									
Other:									

Past Medical History:

Please check all that apply

	Yes	No		Yes	No		Yes	No
Allergies: Food			Diarrhea			Rheumatic Fever		
Allergies: Seasonal			Ear Infections			Seizures/Epilepsy		
Anemia			Hearing Problems			Vision Problems		
Asthma			Heart Disease			Other:		
Constipation			Pneumonia					

Communicable Diseases:

Has the patient ever had any of the following communicable diseases?

	Yes	No		Yes	No		Yes	No
Chickenpox			Measles			Mumps		
Rubella			Meningitis			Tuberculosis (TB)		

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.

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)

COAST COMMUNITY HEALTH center

Consent for Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily consent for provider (Medical Doctor, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

HIPAA 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 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 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 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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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

Authorization to Leave Message

Signing below gives the staff at Coast Community Health Center permission to leave messages with members of your household or on your answering machine/voice mail. You have the right to revoke this consent in writing.

Yes_____ No_____

Patient Name:_____

Birthdate:_____ Today's Date:_____

Signature:_____

Authorization to Discuss Medical Information with Family Members

Signing below will give your doctor, nurse, medical assistant, or other staff members at Coast Community Health Center permission to discuss your medical information with the family members or friends/caregivers indicated below.

_____NONE: PLEASE DO NOT DISCUSS MY MEDICAL INFORMATION WITH ANYONE.

OR

I, _____, give the staff and physicians at Coast Community Health Center permission to discuss/release my medical information to the following individual(s):

Name:_____

Relationship:_____Phone Number:_____

Name:_____

Relationship:_____Phone Number:_____

Name:_____

Relationship:_____Phone Number:_____

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)	**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. **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. **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: _____

5. **Are you Latino or Hispanic Ethnicity?** ☐ Yes ☐ No

6. **Are you a Veteran?** ☐ Yes ☐ No

7. **Please state your household's approximate pre-tax income:** $_____ per _____ (year/month/week)

8. **What is the number of individuals living in your household which should include self, spouse, and dependents?** _____

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	Diagnostic Tests
Chart Notes	Diagnoses	Operative Reports
Labs	Mammogram	Radiology
Immunizations	Pap Smear	Consultation Reports
Food/Drug Allergies	Colonoscopy	Pathology Reports

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

Ages (13-17) *Revised 9/11/2019*