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 – 6 pm
Friday 8 am – 5 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)		

Birth History:

If patient is under 1 year of age, please answer the following questions:

Birth Weight/Length: ____lbs ____oz ____inches

Was your child born prematurely? ___Yes ___No If yes, how early? ____________________________________

Method of Delivery: ___Vaginal ___Caesarean If Caesarean, why? ______________________________________

Were there any medical problems during pregnancy? ___Yes ___No

If yes, please explain: ____

Were there any problems after the patient's birth? ___Yes ___No

If yes, please explain: ____

For Male Patients Only: Is your child circumcised? ___Yes ___No

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 Discount Program.
- 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 Discount Program

- You may qualify for the Sliding Fee Discount Program. The Sliding Fee Discount Program is based on your household size and income. Please ask us for our Sliding Fee Discount Program application. You can also review it on our website at www.coastcommunityhealth.org.
- To qualify for the Sliding Fee Discount Program, you will 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

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
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)		

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

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)
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
8. **Please state your household's approximate pre-tax income:** $_____________________ per __________
   (year/month/week)
9. **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