Southeast Community Health Systems Medical Patient Registration

Email completed registration form to telemed@shchc.org

PATIENT INFORMATION

Last Name	First Name	MI	DOB	SS#

Street Address	**City**	**State**	**Zip**	**County**

CONTACT INFORMATION

Primary Phone Number		Secondary Phone Number	
	□ Home □ Cell □ Work		□ Home □ Cell □ Work
Do you need transportation? □**Yes** □ **No**		**Email:**	

PATIENT DEMOGRAPHICS

Primary Language Spoken
□ English □ Spanish □ Other_____

Would you like an interpreter?
□Yes □ No

Race (Check all that apply)
□ Black/African American □White
□Asian □ Unreported/Refused to Report
□ American Indian/Native Alaskan
□ Other Pacific Islander
□ Native Hawaiian
□ Other
_____

Ethnicity
□ Hispanic/Latino
□ Non-Hispanic/ Latino
□ Cuban
□ Puerto Rican
□ Another Hispanic, Latino or Spanish Origin
□ Unreported/Refused to Report

Place of Birth (City, State)

Gender Identity:
Do you think of yourself as:
□ Male
□ Female
□ Female-to-Male/Transgender Male/Trans Man
□ Male-to-Female/Transgender Female/Trans Woman
□ Genderqueer, neither exclusively male nor female

Sexual Orientation:
Do you think of yourself as: □ Straight or heterosexual
□ Lesbian, gay, or homosexual
□ Bisexual
□ Unknown
□ Other, please specify:
□ Refused to Report
_____

Marital Status
□ Single
□ Married
□ Divorced
□ Widowed
□ Separated
□ Life Partner

Student
□ Full-Time
□ Part-time
□ Not a Student, highest grade completed?
_____

Employment Status
□ Full-Time
□ Part Time
□ Not Employed
□ Retired
□ Disabled
□ Student
□ None

Employer **Phone No.**

Housing Status: □ Not Homeless □ Homeless
□ Other □ Doubling Up □ Public Housing □ Transitional
□ Street □ Homeless Shelter

Primary Care Provider
_____
Pharmacy_____
Phone No. _____

Military Veteran?
□ Yes
□ No

Agriculture Status
□ Migrant Worker
□ Seasonal
□ Dependent of Migrant
□ Dependent of Seasonal
□ Not Agricultural Worker

GUARANTOR (Person To Be Billed, Check here if same as patient □)

Last Name	**First Name**	**MI**	**DOB**	**SS#**

Street Address	**City**	**State**	**Zip**	**Home Phone**	**Cell Phone**

EMERGENCY CONTACT (Someone outside of your home that we may contact in an emergency)

Last Name	**First Name**	**Relationship**

Street Address	**City**	**State**	**Zip**	**Home Phone**	**Cell Phone**

NEXT OF KIN (Check here if same as emergency contact □)

Last Name	**First Name**	**Relationship**

Street Address	**City**	**State**	**Zip**	**Home Phone**	**Cell Phone**

Southeast Community Health Systems

FAMILY INCOME INFORMATION

We request income on all patients for governmental reporting purposes.
If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application

Income Period: □ Weekly □ Bi-weekly □ Monthly □ Quarterly □ Annually □ Other _____
Gross Household Income: $_____ Number of individuals income supports: _____

INSURANCE INFORMATION

Please allow our staff to copy/scan your insurance card

PLAN # 1 Information

Insurance Company: _____
Member ID #:_____ Group #:_____
Patient's Relation to Subscriber: □ Self □ Child □ Parent □ Spouse □ Employer □ Other_____
**********If Patient is Subscriber (No need to complete the rest of this section)**********
First Name:_____ Middle Name:_____ Last Name:_____
Suffix:_____ Social Security Number:_____ Gender: □ Male □ Female
Date of birth (mm/dd/yyyy): _____
Street Address:_____ City:_____ State:_____
Zip:_____ Home Phone:_____ Mobile/Cell Phone:_____

PLAN # 2 Information

Insurance Company: _____
Member ID #:_____ Group #:_____
Patient's Relation to Subscriber: □ Self □ Child □ Parent □ Spouse □ Employer □ Other_____
**********If Patient is Subscriber (No need to complete the rest of this section)********** First Name:_____ Middle Name:_____ Last Name:_____ Suffix:_____ Social Security Number:_____
Gender: □ Male □ Female
Date of birth (mm/dd/yyyy): _____
Street Address: _____ City: _____ State: _____

INSURANCE ASSIGNMENT: I assign directly to Southeast Community Health Systems (SCHS) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize SCHS to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions and for a copy for this statement and my signature to be kept on file and used in place of this original.

Patient/Guarantor Signature _____ Date: _____/_____/_____

Sliding Fee Scale Application

Date: / /

First Name: Middle Name: Last Name:

Household Size				
Name	Relationship	Date of Birth	Social Security Number	Income
	Head of Household			

Total Gross Income: $_____

NOTE: To comply with federal regulations, to give you a discount on our medical-dental services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income annually. Please bring yearly income tax return, last month's paycheck stubs, copies of your social security-food stamps award letters, or other supporting documents you may receive as proof of family income. Only the family size and annual gross income will be used to determine your eligibility and calculate your discount.

Sliding Fee Scale Discount Rates (Copy of Sliding Fee Scale available upon patient's request)

Medical Nominal Fee for Scale "A" - $30 for new patients
$25 for established patients

Dental Nominal Fee for Scale "A"- $40

All other office visits and/or procedures are discounted at the following percentages:

B-50% Discount
C-35% Discount
D-20% Discount
E- 0% Discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Southeast Community Health Systems if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Southeast Community Health Systems. I hereby acknowledge that I read the foregoing disclosure and understand it.

Last Name _____First Name _____

Signature of Patient or Guardian _____ Date _____/_____/_____

Southeast Community Health Systems

Patient Name: _____ **Birth date:** _____/_____/_____**Date:**_____/_____/_____

GENERAL CONSENT FOR TREATMENT

1. I hereby authorize and consent to all necessary medical procedures needed for diagnosis and treatment for me and/or my dependents by Southeast Community Health Systems (SCHS).
2. I understand that no guarantee or assurance has been made as to the results that may be obtained.
3. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees of a cure have been made to me as a result of examinations or treatments by SCHS.
4. I give permission to release to my insurance company medical information necessary in the filing of lawful claims by SCHS' staff for services rendered by SCHS to me or my dependents.
5. I hereby authorize payment directly to SCHS of benefits relative to pending claims and/or Major Medical benefits otherwise payable to me, not to exceed SCHS' regular charges for this service.
6. I certify that the information that I have provided in applying for payments under Title XVII of the SSA Act is correct. I authorize any holder of medical or other information intermediaries, carriers, or any other insurer, any information needed for this or any related Medicare/Medicaid Claims. I request benefits be paid on my behalf.
7. I agree that a photocopy of this form is as valid as the original.
8. I agree and understand that the medical records are the property of SCHS; however, I can request a copy for a nominal fee at any time.
9. I certify that the information provided is true to the best of my knowledge.

Signature of Patient (or Guardian): _____Date: _____

PATIENT RIGHTS

Make known immediately to any member of administration any problem(s) encountered during a visit to the health center. If a member of the organization cannont address your concern(s), you are encouraged to contact SCHS' *Corporate Compliance Officer* at (855) 368-6272 or Compliance@shchc.org to report your concern. I have read and understand my rights and responsibilities as a patient of SCHS and understand that if I believe the quality of my healthcare is compromised and if SCHS administrative staff or Corporate Compliance cannot address it in a timely fashion, I have the option to report my concern to the Joint Commission at (800) 994-6610 or Complaint@jointcommission.org.

PATIENT RIGHTS Signature of Witness (when patient requires reading of rights):_____

PATIENT RESPONSIBILITY

1. I acknowledge that I am fully responsible for any and all expenses incurred at Southeast Community Health Systems for myself and/or dependents/family members.
2. I understand that all payments are due at the time of service.
3. I understand that all payments must be made towards any outstanding balance in addition to the payment for the current date of service rendered.

Signature of Patient (or Guardian): _____ Date: _____

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

I understand that Southeast Community Health Systems does not honor Advanced Directives. In the event of a medical emergency during the clinic visit, first aid measures will be provided, 911 called and hospital transfer initiated.

Signature of Patient: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.
I wish to place the following restrictions on disclosure of my health information (Please list below or write N/A if no restrictions):

_____

Signature: _____ Date: _____/_____/_____

Relationship to patient if not signed by patient: _____

Southeast Community Health Systems
MEDICAL HISTORY

Patient Name: _____ **Birth date:** _____/_____/_____ **Date:**_____/_____/_____

Past and Present Illness

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Seizures
- ☐ Blood Clots
- ☐ Depression
- ☐ Anxiety
- ☐ Anemia
- ☐ Asthma
- ☐ Frequent Vaginal Infections
- ☐ Frequent Bladder Infections
- ☐ Peptic Ulcer Disease
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Attack
- ☐
- ☐

Surgery

- ☐ Tonsils
- ☐ Appendix
- ☐ Gallbladder
- ☐ Hernia
- ☐ Breast
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ C-Section
- ☐ D & C
- ☐ Heart
- ☐ Thyroid
- ☐ Stomach
- ☐ Hernia
- ☐ Other (List Below)
- ☐ STD's
- ☐ Risky Sexual Behaviors

Family History (state which family member/s has illness):

Illness/Condition	which family member suffers from each?
Diabetes	
Heart Attack	
High Blood Pressure	
Stroke	
Seizures	
Glaucoma	
Thyroid Disease	
HIV/AIDS	
Migraines	
Mental Illness	
Kidney Disease	
Arthritis	
Cancer	
Type	
Female Cancer	
Male Cancer	

Do you live with someone who has Tuberculosis (TB)? ☐ Yes ☐ No
Do you live with someone who has HIV? ☐ Yes ☐ No
Do you live with someone who has Hepatitis? ☐ Yes ☐ No
Do you live with fear of abuse or violence in the home? ☐ Yes ☐ No
Do you live with anyone who smokes or uses drugs? ☐ Yes ☐ No

Languages & Barriers

Language(s) Spoken:

Barriers: Language: _____
Reading: _____
Hearing: _____
Vision: _____

Preferences for Learning

Preference for Learning: _____ Written
_____ Visual
_____ Verbal
_____ Demonstrated

Arthritis

Do you exercise? _____
Do you watch fat, salt and cholesterol in your diet? _____
Do you have any other problems or conditions SCHS should be aware of?_____

Other Surgeries: _____

Current Medications: _____

List of Allergies: _____

Cultural Beliefs: _____

Appointment Confirmation & Cancellation Policy

We understand that unplanned issues can come up, and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be canceled at least 24 hours in advance. Our providers want to be available for your needs, and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancelation policy, circumstances have caused us to enforce our revised policy.

Cancelation Policy

After the second missed appointment or no show, the patient will not be allowed to schedule an appointment with our office for 6 months. The patient can only have same day appointments if available.

Confirmation Policy

If a patient does not confirm their appointment within 24 hours of the appointment time, they will be taken off the schedule, and their appointment slot will be filled.

As of March 8, 2017, this policy is effective. Thank you for being a valued patient, and for your understanding, and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

_____	_____	____/____/____
Printed name	Signature	Date

Albany 225.306.2050
Greensburg 225.306.2070
Independence 225.306.2060
Kentwood 225.306.2100
Zachary 225.306.2000
Picardy 225.763.4990

The **Southeast Community Health Systems** Patient Portal provides an easy-to-use, secure, web-based method for patients to access portions of their medical records on-line. This is available from any computer (desktop, laptop or tablet) with Internet access. When you log into the **Southeast Community Health Systems** Patient Portal, you will be able to view information, including your medical conditions, medications, vital signs, lab results, allergies, and insurance policies.

Register for the Southeast Community Health Systems Patient Portal

Use this form to request a **Southeast Community Health Systems** Patient Portal account.
Once you have been registered for the **Southeast Community Health Systems** Patient Portal, you will receive an email from **Southeast Community Health Systems** with instructions to complete your Patient Portal registration.

Patient Registration Form

By completing this form, you are authorizing to set up a *Southeast Community Health Systems* Patient Portal Account.

Please complete using CAPITAL LETTERS with one character in each block.

FIRST NAME:	
LAST NAME:	
DATE OF BIRTH:	/ /
Last 4 Digits of SSN	
EMAIL ADDRESS:	
ZIP (Postal) Code #	-
Signature:	
Today's Date	/ /

☐Yes, I would like to be enrolled in the Southeast Community Health Systems Patient Portal.

Please allow 3 business days for your request to be processed.
A Southeast Community Health Systems representative may contact you to verify your information.

SOUTHEAST COMMUNITY Health Systems
Health, Vitality & Wellness

Name_____ **Date of Birth**___/___/____ **Date**____/_____/_____

The Generalized Anxiety Disorder 7 – Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless that it is hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Some-what difficult ☐	Very difficult ☐	Extremely difficult ☐

Add Columns: _____ + _____+ _____

Total Score: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ – 9)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Some-what difficult ☐	Very difficult ☐	Extremely difficult ☐

Add Columns: _____ + _____ + _____

Total Score: _____

SOUTHEAST COMMUNITY Health Systems
Health, Vitality & Wellness

Name: _____ Date of Birth: ____/____/____ Date: ____/____/_____

Domestic Violence Screening Tool

Instructions: This is a screening measure to help you determine whether you might be involved in an abusive relationship that needs attention. This screening measure is not designed to make a diagnosis or take the place of a professional diagnosis or consultation. For each item, indicate the extent to which it is true, by selecting the appropriate box next to the item.

1. Do you feel anxious or nervous when you are around your partner?	☐ No	☐ Sometimes	☐ Regularly
2. Do you watch what you are doing in order to avoid making your partner angry or upset?	☐ No	☐ Sometimes	☐ Regularly
3. Do you feel obligated or coerced into having sex with your partner?	☐ No	☐ Sometimes	☐ Regularly
4. Are you afraid of voicing a different opinion than your partner?	☐ No	☐ Sometimes	☐ Regularly
5. Does your partner criticize you or embarrass you in front of others?	☐ No	☐ Sometimes	☐ Often
6. Does your partner check up on what you have been doing, and not believe your answers?	☐ No	☐ Sometimes	☐ Often
7. Is your partner jealous, such as accusing you of having affairs?	☐ No	☐ Sometimes	☐ Often
8. Does your partner tell you that he or she will stop beating you when you start behaving yourself?	☐ No	☐ Yes	
9. Have you stopped seeing your friends or family because of your partner's behavior?	☐ No	☐ Yes	
10. Does your partner's behavior make you feel as if you are wrong?	☐ No	☐ Sometimes	☐ Regularly
11. Does your partner threaten to harm you?	☐ No	☐ Sometimes	☐ Regularly
12. Do you try to please your partner rather than yourself in order to avoid being hurt?	☐ No	☐ Sometimes	☐ Regularly
13. Does your partner keep you from going out or doing things that you want to do?	☐ No	☐ Sometimes	☐ Regularly
14. Do you feel that nothing you do is ever good enough for your partner?	☐ No	☐ Sometimes	☐ Regularly
15. Does your partner say that if you try to leave him or her, you will never see your children again?	☐ Yes	☐ No	☐ Not Applicable
16. Does your partner say that if you try to leave, he or she will kill him or herself or you?	☐ No	☐ Sometimes	☐ Regularly
17. Is there always an excuse for your partner's behavior? ("The alcohol or drugs made me do it! My job is too stressful! If dinner was on time I wouldn't have hit you! I was just joking!")	☐ No	☐ Sometimes	☐ Regularly
18. Do you lie to your family, friends and doctor about your bruises, cuts and scratches?	☐ Yes	☐ No	☐ Not Applicable

Name: _____ **Date of Birth:** ____/_____/_____ **Date:** ____/____/_____

CAGE Questions Adapted to Include Drug Use (CAGE-AID)-Drugs

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐ YES / NO ☐
2. Have people annoyed you by criticizing your drinking or drug use? ☐ YES / NO ☐
3. Have you felt bad or guilty about your drinking or drug use? ☐ YES / NO ☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ☐ YES / NO ☐