PATIENT PROFILE

Doctor: ______________________ Date: ______________

PATIENT INFORMATION

Name: ______________________

Preferred: ______________________

Address: ______________________

____

City, State: ______________________

Phone: ______________ ☐ Mobile ☐ Home ☐ Work

Phone: ______________ ☐ Mobile ☐ Home ☐ Work

Phone: ______________ ☐ Mobile ☐ Home ☐ Work

Pt ID# /MRN: ______________ Sex: ☐ M ☐ F

Date of Birth: ______________________

Social Security #: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced

Primary Physician: ______________________

Preferred Language: ______________________

Email Address: ______________________

ADDITIONAL INFORMATION

Race:
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ More Than One Race
- ☐ Asian
- ☐ Other Pacific Islander
- ☐ Native Hawaiian
- ☐ American Indian/Alaskan Native

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Agricultural: Worker Status:
- ☐ Non-Agricultural
- ☐ Seasonal
- ☐ Migrant
- ☐ Employed Year Round
- ☐ Retired Farm Worker

EMERGENCY CONTACT

Name: ______________________

Phone: ______________________

Relationship: ______________________

PHARMACY

Name: ______________________

Veteran Status: ☐ Veteran ☐ Non-Veteran

Homeless Status:
- ☐ Not Homeless
- ☐ Homeless Shelter
- ☐ Transitional
- ☐ Doubling Up
- ☐ Street
- ☐ Other

GUARANTOR

☐ Self ☐ Parental Guardian ☐ Spouse ☐ Partner ☐ Other

Name: ______________________

Address: ______________________

____

City, State: ______________________

Phone: ______________________

Alt Phone: ______________________

Social Security #: ______________________

Date of Birth: ______________________

PRIMARY INSURANCE

Insured Party: ______________________

Company: ______________________

Relationship to Insured: ______________________

Insured Date of Birth: ______________________

SECONDARY INSURANCE

Insured Party: ______________________

Company: ______________________

Relationship to Insured: ______________________

Insured Date of Birth: ______________________

FAMILY SIZE/INCOME (voluntary for all patients for grant)

Family Size: __________ Annual Income: ______________

Sexual Orientation:
- ☐ Straight (Not Gay or Lesbian)
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Something Else
- ☐ Do Not Know
- ☐ Choose Not to Disclose

Gender Preference:
- ☐ Male
- ☐ Female
- ☐ Transgender Male/Female-to-Male
- ☐ Transgender Female/Male-to-Female
- ☐ Other

Pronoun Preference: ☐ He ☐ She

I consent to the medical, behavioral health, nutrition, or dental examination treatment and procedures which may be performed during the office visit, including emergency treatment considered necessary by the medical, behavioral health, nutrition, or dental health provider. Hepatitis C or HIV screenings may be included as a routine part of care unless I, the patient, elect to decline testing which should be done by notifying the medical provider. I understand that if a medical or dental invasive procedure is necessary, a specific consent form will be discussed with me at that time. I give permission to BRCHS to release any medical, behavioral health, nutrition, or dental information to Medicare, Medicaid, or the insurance company that is needed to receive payment for the medical, behavioral health, nutrition, or dental services rendered to me or the other person listed on this Patient Registration Form. I understand that I am responsible and am required to pay BRCHS any co-pays, deductibles, and charges not covered by Medicare, Medicaid, insurance, and/or any balance due to BRCHS. In the event I do not disclose that I am covered by insurance and BRCHS learns that I am covered, I consent to my insurance carrier being billed for the services rendered. I further consent to being contacted at my preferred method of communication which may include but is not limited to text or email. If I do not wish to be contacted by either of these methods, I will notify the staff that I would like to opt out of these services. Payment of deductibles and copayments are expected each time (and for each service line, if applicable).

Signature: ______________________ Date: ______________

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence. In order to protect the privacy and confidentiality of your information, please complete the following which tells us how you wish for your protected health information (PHI) to be used.

BRCHS may share my protected health information (PHI) with the following persons:

Family Members Name/s ____

Other/s Name/s ____

BRCHS is authorized to leave and/or text messages, including medical information, with a call-back number at this number and on voicemail or answering machine, if applicable.

Home Number ______________________________

◯ Do Not Contact me at home telephone number.

Cell Number ______________________________

◯ Do Not Call me at the cell telephone number.

◯ Do Not Text me at cell telephone number.

My Primary contact number is my: ◯ **Home Telephone** ◯ **Cell Phone**

Note: Your primary contact number will be used for appointment reminders unless otherwise noted above.

<u>WRITTEN COMMUNICATION</u>

BRCHS will send information to me via my home address, including medical information and results, as needed.

◯ Mail information to another address

____

____

◯ Please, do not send written information to me.

◯ Fax information to the following number:______________________

<u>EMAIL COMMUNICATION</u>

BRCHS can communicate with me through email: ____________________ @ ______________.

(Patient Authorization Form for email on the reverse side MUST also be signed.)

◯ I do not want to communicate by email.

I understand that BRCHS will continue to communicate with me according to my above response(s) until I change my preferences. I may do so by completing a new form or making my request in writing. Furthermore, I understand that if I want BRCHS health care providers to call me back after hours, my phones should be able to receive calls from a restricted number. By my signature below, I agree to be communicated with in the above manner.

Patient/Parent/Legal Guardian Signature: ______________________________

Date: ____

BRCHS Staff Signature/Witness: ____

(Over)

PATIENT AUTHORIZATION TO USE E-MAIL AND TEXTING FOR COMMUNICATIONS OF CLINICAL INFORMATION

I hereby authorize Blue Ridge Community Health Services (including any affiliates, subsidiaries, and any entities in which Blue Ridge Community Health Services or its affiliates of subsidiaries has an interest) (collectively, "BRCHS") to utilize electronic mail to communicate clinical information to me pertaining to health care services that have been rendered to me. I acknowledge and understand that such E-Mail and texts may contain personal and private medical information of mine including, but not limited to, my name, address, social security number, date of birth, race and ethnicity demographics, types and dates of health care services received, name and address of the provider administering each health care services, insurance coverage information and/or test results (the "Medical Records").

I acknowledge and understand that, although BRCHS may engage in certain practices in order to protect the privacy of the contents of any E-Mail or text message sent to me and will take all reasonable measures to protect my privacy, the E-Mail or text messages sent to me are not encrypted and travel over the Internet and my cell phone service provider, as a result, there is a risk that the E-Mail or texts will be intercepted and read by third parties to whom the E-Mail or text is not directed. In authorizing BRCHS to send me E-Mail or texts, I assume the foregoing risk.

I understand that E-Mail and texts are not an appropriate medium for conveying information relating to urgent or emergency medical matters and that I will use the telephone as my means of communication with BRCHS or any other appropriate health care provider as the situation may warrant.

I understand that, by authorizing BRCHS to send me E-Mail or text messages, certain employees and agents of BRCHS may have access to my e-mail address and cell phone numbers along with E-Mail and text messages content, such as triage nurses, physicians and other health care providers that are permitted access to my medical records.

I acknowledge that I, and not BRCHS, am responsible for the security of E-Mail and text message communications sent from or stored on my computer, cell phone, or information system, including, but not limited to, protecting access to any E-Mail or text messages stored on my computer, cell phone, or information system, implementing security measures when delivering E-Mail and test messages from my computer, cell phone, or information system and implementing virus protection on my computer or information system.

I hereby authorize BRCHS to retain my e-mail address in its databases so that it may send me future communications regarding its services, fund raising activities and other matters relating to BRCHS's business. I understand that I may revoke this authorization at any time by providing written notice, electronically or otherwise to BRCHS- HIPAA Privacy Officer, 2579 Chimney Rock Road, Hendersonville, NC 28792. I acknowledge that BRCHS will only use my e-mail address and cell phone number (text messages) for BRCHS business purposes and that it will not sell, transfer or otherwise disclose my e-mail address, cell phone number, or any of my other personal information to any third parties without my prior consent.

I understand that my decision to permit BRCHS is voluntary, and that treatment is not conditioned upon my lection to do so.

I understand and agree not to hold BRCHS liable for any damages resulting from their use of E-Mail and text messaging in accordance with the terms of this authorization or the failure in any manner of any BRCHS information systems used to facilitate the delivery of such E-Mail and text messaging..

I have read and fully understand the meaning of this authorization.

A photocopy or facsimile copy of this authorization is valid as the original.

Print Patient's Name: ______________________________

Patient/Parent/Legal Guardian Signature: ______________________________

Date: ______________________________

BRCHS Staff Signature/Witness: ______________________________

Rev 9-2018

Patient Acknowledgement

Receipt of Patient Privacy Rights
(HIPAA)

Patient Rights and Responsibilities
and Patient Financial
Responsibilities

I acknowledge that I have received a copy of the Blue Ridge Community Health Services, Inc. Patient Privacy Rights (HIPAA), Patient Rights and Responsibilities and Patient Financial Responsibilities.

____	________________________
Patient/Parent/Guardian's Printed Name	Patient's Date of Birth
____	________________________
Patient/Parent/Guardian's Signature	Date
____	________________________
Witness	Date

APPLICATION FOR DISCOUNT SERVICES

Patient Name:____ **Phone:** ____________________________

Please mark each statement that applies to you or a family member who is also on this application. **<u>This information will not be used to withhold or deny services to you or your family.</u>**

I. SLIDING FEE SCHEDULE

As a Federally Qualified Health Center, BRCHS offers a Sliding Fee discount program for those who qualify. **You may receive the discounted rate even if you have private insurance**, Marketplace insurance, or Medicare, if the discounted rate is lower than your normal out-of-pocket cost. If you are not eligible for the sliding fee scale, choose not to apply, or do not provide household and income information, you will be expected to pay the full charge for care. (See the **Acknowledgement if NOT applying for Sliding Fee Schedule** at the end of this document).

I would like to see if I qualify for discount services under BRCHS's Sliding Fee Schedule. Yes _______ No __________

II. ELIGIBILITY VERIFICATION:

Household information: Please include yourself, your spouse/partner and all dependents living in the home below:

Name	Date of Birth	Relationship to You	Type of Health Insurance?	Farmworker in past 2 years?	Veteran?
		Self			

Gross Income: Please list your household's **<u>gross income</u>** (the $ amount received before taxes are taken out). Household income includes *everyone* in the home. Proof of income includes: most recent tax return, check stubs, Social Security statement, letter from employer stating wages earned, or proof of unemployment.

Income type (i.e. Wages, Soc. Sec., Child Support, other income)	**Name of Family Member**	**Gross Amt.** (pre-tax)	**Frequency** (weekly(x52), bi-weekly (x26), bi-monthly (X24) or monthly (x12).)
		$	
		$	
		$	

If there is no income to report, or if you are unable to document your income, you must complete the **Patient Certification Statement** section below.

<u>Patient Certification Statement</u>

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the BRCHS Sliding Fee Discount Schedule. I understand that BRCHS officials may verify information on this form.

Patient Signature____ **Date**____________________________

REV 08/18 .SFS INTAKE-ENG

[OVER PLEASE]

Acknowledgement if NOT applying for Sliding Fee Schedule

I have been given the opportunity to apply for the BRCHS discount services sliding fee schedule, and **I do not wish to apply for the BRCHS discount services sliding fee program** at this time, or have been told that I do not qualify for a sliding fee discount. I understand that if I do not have insurance at the time of service, I will be responsible for any and all balances due after the provider's charges for my visit are entered. I will also be responsible for any lab and/or x-ray charges for today's visit. Any discount for office charges or lab charges is not applicable and I will not be allowed to receive a retroactive discount for these charges in the event that a future sliding scale application is completed.

Patient Signature_______________________________________ **Date:** _________________________

Consent for Application for Discount Services

I certify that the **information provided above is accurate and complete** to the best of my knowledge. In the event of a change in income or insurance coverage, I will notify BRCHS at my next appointment. I understand that **I will be financially responsible for all or a portion of my care** and that I will be **asked to submit payment at the time of service**. I authorize the release of any information necessary to establish my family's eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled. I understand that BRCHS uses a system called Oasis Insight or an Electronic Health Record to help determine eligibility for sliding fee and other services and I consent to have the above information stored in those systems.

Patient Signature____ **Date**____________________

III. POTENTIAL BARRIERS TO CARE

This list is used to help us identify other areas in your life that may need some additional community resources. It will help us develop a plan of action, including referrals to appropriate departments and outside organizations. If you would like more information, or have any question on the items below, check the box so that a Patient Navigator can assist you.

Health Insurance / Health Care Access

- ☐ I need health insurance (Medicaid, ACA Insurance, Family Planning, or other programs)
- ☐ I need to sign up for Medicare or need Medicare Counseling (SHIIP)
- ☐ I need help completing a Charity Care applications for my local hospital system
- ☐ I need help paying for my medications (This does not include usage of a discounted medication or medication assistance program.)
- ☐ I need to apply for a tax exemption because I'm uninsured
- ☐ My application for Medicaid/ACA insurance was denied
- ☐ I need help getting to other important appointments

Housing

- ☐ I do not have housing (living in shelter, with friends, in a car, in a park, etc.)
- ☐ I would like assistance to find affordable housing
- ☐ I am at risk of losing my housing

Housing (Continued)

- ☐ There are unsafe conditions at my home (mold, leaks, peeling paint, etc.)
- ☐ I have difficulty paying heating/utility bills

Food

- ☐ I sometimes or often do not have enough food for myself and/or my family
- ☐ I would like to apply for Food Stamps (SNAP) benefits
- ☐ I was denied Food Stamps (SNAP)

Transportation

- ☐ I need help going to medical appointments
- ☐ The bus system does not go near where I live or work

Other

- ☐ I would like to register to vote
- ☐ I need help filing my taxes
- ☐ My disability application was denied
- ☐ Other barriers/challenges:
  ____
  ____

None:

- ☐ I do not need assistance at this time

Blue Ridge Staff Name____________________Slide (A-E):___________Entered into EHR (initials)__________

PERMISSION TO PHOTOGRAPH

I agree that Blue Ridge Health (BRH) may take a digital photo of me. I understand that:

- The photo will be stored permanently in my electronic medical record.
- The photo will be used to identify me when I come to BRH for care.
- The photo will be stored securely to protect my privacy.
- The photo will NOT be used outside of BRH, unless I (or my legal representative) give my permission in writing.
- BRH will own the photo. I can look at the photo or request copies, if I (or my legal representative) sign a medical records release form.
- My BRH provider may use their phone to take a picture of me for diagnostic purposes. I understand that this photo will be taken with Athena Capture and stored on a secure US-based server. These photos are not stored on my BRH provider's actual phone server. This photo will also become a permanent part of my electronic medical record (Athena One).

To be completed by patient:

☐ I accept ☐ I decline

____
Patient's printed name

____
Patient's signature (or person authorized to sign for patient)

____________________ ____________________
Relationship to patient Date

Administrative Offices
220 5th Avenue East
Hendersonville, NC 28792

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

RELEASE INFORMATION FROM:

	Blue Ridge Health	Or		**Other Facility:**

TO USE OR DISCLOSE TO:

Name of Person or Facility:				
Address	City		State	Zip
Phone:	Fax:	Email:		

The protected health information of:

Patient Name:		Date of Birth:		SS# (last 4):
Address	City		State	Zip
Phone:		BRH Medical Record #		

Dates of Service:__________________________________

Information authorized for disclosure, *if included in my records*:

◻ **Complete health record** ◻ Visit/Discharge Summary ◻ History & Physical ◻ Patient Billing Records
◻ Consultation Reports ◻ Clinical office notes ◻ Medication history ◻ Problem/Diagnosis List
◻ Medication List ◻ ◻ Immunization records ◻ Radiology & Diagnostic Imaging Results
◻ Laboratory Tests (specify): ____
◻ Other (specify); ____

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing unless limited by the above selection. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy notes requires a separate authorization.

Put a CHECKMARK next to the purpose of the request:

◻ Continued Patient Care ◻ Insurance ◻ Benefit Eligibility ◻ Personal Use
◻ Attorney/ Legal ◻ Other ______________________________________

Put a checkmark next to how you would like to receive your request:

	Mail to address listed above			Verbal Release
	Fax to # listed above (health care providers only; no personal faxes			Review in administrative office
	Pick up at clinic location:			Receive electronically at email above

I understand:

- I may revoke this Authorization at any time:
    - The revocation will not apply to information that has already been released in response to this Authorization.
    - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the BRH Medical Records Department.
- I may refuse to sign this Authorization:
    - My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure.
    - A fee may be charged for providing the protected health information. Please contact BRH Medical Records at 828.692.4289

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: __________________. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

Blue Ridge Health, its employees, officers, and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I have read and understand the information in this Authorization form.

Signature of Patient:	
Printed Name:	Date:

Signature of Authorized Representative:	
Printed Name:	Date:
Please explain Representative's authority to act on the behalf of the Patient:	

OFFICIAL USE ONLY
Name/Title of Person Releasing Information:
____

Date disclosure completed _____/_____/_____ Sent Via: ◻ USPS Mail ◻ Fax ◻ Encrypted Email

Date this authorization was revoked: ____________________________