Welcome!

We welcome you and thank you for choosing our Community Health Center as your medical home. Our mission is to be a leading provider of quality healthcare for our diverse community.

We are here for you:

- We will do our best to offer you same-day office visits
- During our *normal office hours*, we have a Communication Nurse available to you for medical questions or concerns.
- We provide 24-hour access for medical advice at all of our locations. You may access at your providers office.
- We offer a Sliding Scale Fee Discount Program to help make healthcare more affordable for you and your family. Please ask our Front Office staff to assist you in applying today!

CONVENIENTLY SERVING YOU IN THE FOLLOWING LOCATIONS

Harrisonburg Community Health Center (HCHC)
CHC Main Site

1380 Little Sorrell Drive Suite 100
Harrisonburg, VA 22801

Health Services (1st Floor)

Phone: 540-433-4913
Fax: 540-433-4915

Office Hours:

Monday	7:30 am – 5 pm
Tuesday	7:30 am – 6 pm
Wednesday	7:30 am – 6 pm
Thursday	7:30 am – 6 pm
Friday	7:30 am – 5 pm

Dental Services (2nd Floor)

Phone: 540-236-3688
Fax: 540-236-3699

Office Hours:

Monday	8 am – 5 pm
Tuesday	8 am – 5 pm
Wednesday	8 am – 5 pm
Thursday	8 am – 5 pm
Friday	8 am – 12 pm

Community Health Center of Elkton (CHCE)

800 Shenandoah Avenue
Suite 170
Elkton, VA 22827

Phone: 540-298-9900
Fax: 540-298-8991

Office Hours:

Monday	8 am – 4 pm
Tuesday	8 am – 4 pm
Wednesday	8 am – 6 pm
Thursday	8 am – 4 pm
Friday	8 am – 4 pm

VMRC Community Health Center (VMRC CHC)

1491 Virginia Ave,
Harrisonburg, VA 22802

Phone: 540-574-3895
Fax: 540-564-3582

Office Hours:

Monday	8 am – 4 pm
Tuesday	8 am – 4 pm
Wednesday	8 am – 4 pm
Thursday	8 am – 4 pm
Friday	8 am – 4 pm

We welcome you and thank you for choosing Community Health Center as your medical home. It is always our pleasure to assist you with any questions that you may have; feel free to contact us at 540-433-4913.

Sincerely,

Lisa Bricker, RN, MSN
Executive Director

Patient Name: Date Of Birth:

PATIENT INFORMATION					
Last Name	First Name		Middle Initial	Social Security Number __ __ __ - __ __ - __ __ __ __	
Date of Birth __ __ / __ __ / __ __ __ __ m m d d y y y y	Sex Assigned at Birth ☐ Female ☐ Male	Transgender ☐ Yes ☐ No	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		
Mailing Address			City	State	Zip
Physical Address (if different than your mailing address)					
Home phone	Cell Phone		Work Phone		
Would like to sign up for our Patient Portal? Please provide us with your Email address: _____ **(Not familiar with Patient Portal? ask our front desk! We will not share this contact information with any other entities)**					
Employer Name	Employer Address				
	City		State	Zip	
Employment Status ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Self employed					
Student Status ☐ Full time ☐ Part time ☐ Not a student					

RESPONSIBLE PARTY (person to be billed, if other than the patient)				
Last Name	First Name	Date of Birth __ __ / __ __ / __ __ __ __ m m d d y y y y		
Mailing Address (*If different from patient)*	City	State	Zip	
Primary Phone	Relationship to the patient			

Scanned By: Date: Revised 2/2017

Patient Name: Date Of Birth:

CONSENT TO SERVICES AND CARE

Consent for Treatment:
I will allow the Community Health Center to treat the patient. I will provide, when asked, any and all information for any illness or injury, medical history, prescriptions or treatment, and copies of all medical records. I understand that the Community Health Center provides services without regard to race, creed, color, or national origin.

Financial Agreement:
I authorize direct payment to the Community Health Center for any medical care received. I will allow the Community Health Center to file claims on my behalf. I understand that I am responsible for services not paid by my insurance plan, as well as for services used if I did not use the Community Health Center as my Primary Care Provider or if my insurance is not in effect at the time of service.

Notice of Deemed Consent for Infections Disease Testing:
By my signature, I understand that I have been informed of Virginia state code 32. 1-45.1 regarding blood testing: In event that a health care provider or employee is exposed to the patient's bodily fluids in a manner which may transmit disease, the patient will be deemed to have consented to testing for HIV and Hepatitis and to release or disclosure of the test results to that health care provider or employee.

I agree that this permission will be valid until taken away in writing or replaced by one of a later date. A photocopy of this agreement will be considered effective and as valid as the original.

Patient/Guardian Signature:_____ **Date**:__ __/__ __/__ __ __ __
m m d d y y y y

Print Name: _____ **Relationship to Patient**: _____

Tell us the best phone number to reach you at:
Tell us where to call you, leave you messages and appointment reminder: _____ Home _____ Cell _____ Work
Can CHC leave messages on the phone numbers you have provided? ☐ Yes ☐ No If yes, may we leave ☐ Brief or ☐ Extended

Please list all individuals with whom we may discuss your medical care **(HIPPA).**
The individuals on this list will also be part of your emergency contact
We will not discuss your medical care with anyone NOT listed below.

NAME (First and Last)	Primary Phone	Relation to patient

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Patient Name: Date Of Birth:

The following information will help us obtain grants and other funds to continue improving our practice for you.
***THANK YOU* in advance for your assistance.**

RACE (check all that apply):
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American
☐ White (including Latino/Hispanic Descent) ☐ Pacific Islander ☐ Refuse to Report

ETHNICITY:
☐ Hispanic/Latino ☐ Not-Hispanic/Latino ☐ Refused to Report

Primary Language Spoken:

Will you need an interpreter? ☐ Yes ☐ No

HOUSING: ☐ Single Family ☐ Multi-Family ☐ Apartment ☐ Other

Are you a veteran of the US Armed Forces? ☐ Yes ☐ No

LIVING SITUATION: Check which best describes your current living arrangement
☐ Homeless Shelter ☐ Street ☐ Doubling Up (sharing space) ☐ Transitional ☐ Public Housing ☐ Non-Apply

Start Date: __ __ /__ __ /__ __ __ __

Are you or a family member a Migrant Farm Worker (with temporary housing)? ☐ Yes ☐ No
Are you or a family member a Seasonal Farm Worker (without temporary housing)? ☐ Yes ☐ No

Is transportation difficult for you? ☐ Yes ☐ No Primary Transportation:_____

State your houshold size and income in one of the categories listed: House hold size_____
Weekly_____ Monthly_____ Yearly/Annual_____ ☐ Refuse to Report

FOR OFFICE USE ONLY
Qualify for sliding fee discount program?
☐ **100% & below** ☐ **101-150%** ☐ **151-175%** ☐ **176-200%** ☐ **201% & above**

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Patient Name: Date Of Birth:

IN ORDER TO BETTER SERVER YOU, PLEASE REVIEW THE INFORMATION BELOW AND INITIAL HERE ⇩	
CHECK-IN: Please have your insurance card(s) available at check in. The Front Desk representative will take your photograph so that we can accurately identify you at each visit.	
ARRIVAL TIME: If you are an already established patient we ask that you arrive 15 minutes early to your appointments. If you are a new patient your arrival time will be 1 hour early- this is to assure you have a safe and successful appointment.	
HELP US, HELP YOU: Our priority is your health- to get the best out of all your appointments, you are required to bring with you all of your current prescription bottles. This includes herbals, supplements, over the counter medications and any other medications prescribed by other providers.	
PRIVACY PRACTICE: I have read and understand the Community Health Center "Notice of Privacy Practices."	
MEDICAL RECORDS: Community Health Center participates with the prescription monitoring program. I give permission to Community Health Center to obtain medical records from any hospital, practice or pharmacy where I have received services in order to optimize my care. In order to transfer records from a previous provider complete an "Authorization for Release of Protected Health Information" (PHI) form.	
CANCELLATION OF APPOINTMENT: We understand that sometimes you need to cancel or reschedule your appointment. We ask that you notify us with at least 24 hours in advance of your appointment, so we are able to help other patients who are waiting to be seen. To help you remember future appointments, we offer an automated appointment reminder system and an online Patient Portal.	
PAIN MANAGEMENT: Community Health Center manages chronic pain with non-opiate and non-controlled substances. We will assist you with pain management alternatives.	
PRESCRIPTION REFILL: Do not wait until you are completely out of your medication to request a refill. For medication refills, please call your pharmacy to request a refill. Please allow at least 2 to 3 business days for your refill to be available at your pharmacy.	

Patient/Guardian Signature:_____ **Date**:__ __ /__ __ /__ __ __ __
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Print Name: _____ **Relationship to Patient**: _____

The person listed below assisted with this paperwork:

Print: _____

Sign: _____ Date: _____

Scanned By: Date: Revised 2/2017