Tri-Area Community Health

_______ LF _______ Floyd _______ Ferrum

Patient Registration Form

Please print clearly your response to all requested information. If you have questions, please ask. THANK YOU!!!

By providing your e-mail address and cell phone number, you may receive messages from Tri-Area Community Health. Messages can be stopped at your direction.

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Patient Information

Patient's Full Name:____________________ (FIRST) (MIDDLE INITIAL) (LAST) Sex at birth: M F

Address:____________________ (STREET) (CITY) (STATE) (ZIP)

Home Phone: ( )________-____________ Work: ( )________-____________ DOB:______/_____/_______(mm/dd/yyyy)

Email Address:____________________ Cell: ( )________-____________ Are you a veteran? (circle one) Yes No

Social Security #:_____/______/_____ Marital Status: (circle one) S M D W (Single/Married/Divorced/Widowed) Age:__________

Employer:____________________ Phone No: ( )________-____________

Employer's Address:____________________ (STREET) (CITY) (STATE) (ZIP)

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Responsible Party Information

____ Yourself ____Spouse _____ Parent ____ Other

Name:____________________ (FIRST) (MIDDLE) (LAST)

Physical Address:____________________ (STREET) (CITY) (STATE) (ZIP)

Mailing Address:____________________ (STREET) (CITY) (STATE) (ZIP)

Home Phone: ( )________-____________ Work: ( )________-____________ DOB:______/_____/_______(mm/dd/yyyy)

Employer:____________________ Phone No: ( )________-____________

Employer's Address:____________________ (STREET) (CITY) (STATE) (ZIP)

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Insurance Information

Who is the insurance policy holder?: (circle one) Self Spouse Parent - Mother or Father

Name of Policy Holder:____________________ (FIRST) (MIDDLE) (LAST)

Social Security # or Policy ID#:____________________ Policy Holder DOB:____________________

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Emergency Contact

Emergency contact other than spouse:____________________ Relationship to you:____________________
(FIRST) (MIDDLE) (LAST)

Home Phone: ( )__________-________________ Work Phone: ( )__________-________________

PREFERRED PHARMACY: ____________________

City ____________________ Phone number ____________________

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(Form continues on back)

The following information is for public health service grant purposes only. No personally identifiable information is ever reported. By providing this information, you help us continue to receive funding to provide services to the community and special populations. Please select answers below.

RACE: (If more than one race, check all that apply):

- American Indian or Native Alaskan
- Asian
- Black or African American
- Native Hawaiian
- Other Pacific Islander
- White

Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other ____ Is an interpreter needed? ☐ Yes ☐ No

Do you move to different locations to work on a farm or in agriculture? ☐Yes ☐ No

Are you homeless? ☐ Yes ☐ No

If yes, where do you sleep at night? ☐ Shelter ☐ Street ☐ Stay with a friend ☐ Other

Number of people in household _____
Annual household income (please circle one below).

0-$10,000	$25,000-29,999	$50,000-59,999	**Choose not to disclose**
$10,000-14,999	$30,000-34,999	$60,000-69,999	
$15,000-19,999	$35,000-39,999	$70,000-79,999	
$20,000-24,999	$40,000-49,999	$80,000-above	

Current gender: ☐ Male ☐ Female ☐ Other ☐ **Choose not to disclose**

Transgender: ☐ Male to Female ☐ Female to Male

Sexual Orientation: ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ **Choose not to Disclose**

☐ Don't know ☐ Other

Where did you hear about Tri-Area ◊ College ◊ Community ◊ Family/Fr

◊ Health Dept/Social ◊ Newspaper ◊ Other ______________________

Form continues to page 3

AUTHORIZATIONS AND CERTIFICATIONS

I HEREBY AUTHORIZE THE FOLLOWING:

- ***Tri-Area Community Health*** **through its appropriate personnel and/or its medical staff to perform, administer, prescribe, or to have performed, administered, or prescribed upon, to, or for me or any members of my family (including minor children) whose names appear below, such examination, tests, immunizations, injections, and diagnostic procedures as are deemed necessary. I also certify that all information contained herein is true and correct to the best of my knowledge and belief, and that no facts have been omitted.**

- ***Insurance Authorization and Assignment*** **to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.**

- ***Medicare Lifetime Authorization*** **for physical services and request that payment of authorized Medicare benefits to make either to me or on my behalf to Tri-Area Community Health, Inc., d.b.a. Tri-Area Community Health, for any services furnished to me by their physicians. I authorize my holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.**

- ***Deemed Consent for Designated Blood borne Pathogens:***
  Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (AIDS virus) testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility.
  Under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Tri-Area Community Health is directly exposed to body fluids of a patient in a manner which may transmit HIV (AIDS virus) or Hepatitis B and C according to the guidelines of the Centers for Disease Control, Tri-Area Community Health will proceed to test the patient's blood for HIV and Hepatitis B and C. Tri-Area Community Health will provide the results of the test to the patient through his or her primary care provider, and to the health care worker who was exposed. Tri-Area Community Health's policy also protects you as a patient, should you be exposed to the body fluids of a health care worker.

- ***I ALSO CERTIFY*** **that I have read and understand the collection policy of Tri-Area Community Health and agree to abide by it._________(initials)**

- ***I ALSO CERTIFY*** **that I have read and understand the No Show Policy of Tri-Area Community Health and agree to abide by it._________(initials)**

THE INFORMATION PROVIDED ON THIS REGISTRATION FORM IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:_______________________________________ **DATE:**_______________________

Tri-Area Community Health

Tri-Area Community Health Centers
Ferrum, Floyd and Laurel Fork

P. O. Box 9
Laurel Fork, VA 24352
276-398-2292 Phone
276-398-3331 Fax

AUTHORIZATION FOR PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________

I hereby give my permission to the person(s) listed below to receive information about my care:

NAME	RELATIONSHIP	Phone Number
______________________________	______________________	_________________
______________________________	______________________	_________________
______________________________	______________________	_________________
______________________________	______________________	_________________
______________________________	______________________	_________________

____
Signature of Patient, Parent or Guardian

____
Relationship to Patient

____
Date

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____, have received the
(Please Print Patient Name)

Notice of Privacy Practices from Tri-Area Community Health, Inc. at

Laurel Fork, Ferrum, and Floyd.

Signature: ____________________________________ Date: ______________

OR

in lieu of patient signature, I, ____,
(Please Print Your Name)

a staff member of Tri-Area Community Health state that

____ has been given our
(Please Print Patient Name)

current Notice of Privacy Practices.

Signature: ____________________________________ Date: ______________

(FILE IN PATIENT MEDICAL RECORD)