Community Health of Central Washington

Yakima Pediatrics

Registrations forms may be dropped off at Yakima Pediatrics or emailed to YPRegistration@chcw.org or fax to 509-452-5224.

Please be sure to:

- **Complete full registration (everything must be filled out in order to register)**
- **Complete New Patient Transfer of Care Release Form for each of your children**
- **Attach a copy of your ID and patients Insurance Cards**

Please attach all documents and turn them in together.

Once you've registered you will need to contact the patient's insurance and have them assign the patient to our clinic.

Thanks you,
Yakima Pediatrics

Community Health of Central Washington

Patient Registration Form

Guarantor's Information (Person Responsible for Bill)

Guarantor's Name: _____ DOB: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Gender: _____ Email Address: _____

List All New Patients. If pre-registering your newborn, please use due date as date of birth. If transferring from another clinic, you will need to complete a release of record form for each child.

Patient's Name: _____ Gender _____ DOB: _____
Patient's Name: _____ Gender _____ DOB: _____
Patient's Name: _____ Gender _____ DOB: _____
Patient's Name: _____ Gender _____ DOB: _____

What type of Health Insurance do you have?

□ Private Insurance □ Medicaid (Apple Health) □ Coordinated Care □ Molina □ CHPW
□ Open □ Medicare □ No insurance □ Other _____

Insurance ID #_____ Insurance Group: _____
Subscribers Name: _____ Subscribers DOB:_____
Subscribers Gender: Male or Female (circle one)

Secondary Insurance Name: _____
Secondary Insurance ID#: _____ Secondary Insurance Group #:_____
Subscribers Name: _____
Subscribers DOB: _____ Subscribers Gender: Male or Female (circle one)
Subscribers Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Do you receive care from another clinician? □ Yes* □ No
***If you checked "Yes", please provide us with the names of the clinicians below.**
_____

If over 18 years old

Advance Directive in place? □ Yes* □ No □ Living Will □ DPOA □ DNR □ POLST
***If you checked "Yes", please provide us with a copy of the document**

Do you want more information regarding the Advance Directive? □ Yes □ No

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We appreciate that you selected us as your health care provider. We provide services to people with insurance, those with not enough insurance, and those without health insurance. Our clinic receives funding from the government that requires we collect and report information about our patient population; therefore we need you to answer the following questions:

Community Health of Central Washington

Patient's Name: _____ DOB: _____ Medical Record #: _____

How many people live in your household? _____
What is your current household monthly income? (See chart below) _____

What is your primary language? _____
Is the patient Hispanic? (Check one) □ Yes □ No

Mark on the line where your household monthly income would be_____

$----------$7500 and over

$500 $1,000 $2,000 $3,000 $4,000 $5,000 $6,000 $7000

Which of the following group(s) does the patient belong to? (Check only one)

□ Black/African American □ Asian □ American Indian/Alaska Native
□ Native Hawaiian □ Other Pacific Islander □ White
□ More than one race

Interpreter needed? (Check one) □ Yes □ No
Assistance Needed with reading or writing? (Check one) □ Yes □ No
If 18 years or older, is the patient a Veteran? (Check one) □ Yes □ No

Experience with Agriculture (Farm-Work):

1. In the past 2 years have you or anyone in your family worked in any type of agriculture (farm work) like preparing, irrigating, or spraying the fields, nurseries, orchards: planting , picking, sorting, packing or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay or other agricultural products; planting trees: working with Christmas trees; picking pine needles or Spanish moss; taking care of chickens, ducks, turkeys, cows, goats, sheep, fish, clams etc. or doing any other types of farm work, etc. _____Yes _____No

2. In the last 2 years, have you or a member of your family moved to another area and lived away from home in order to work in any type of agriculture (farm work)?_____Yes _____No

3. Have you or a member of your family stopped working in agriculture (farm work) because of disability or age (too old to do the work)? _____Yes _____No

Patient's current living situation:

□ Own/Rent house or apartment (non-homeless) □ Homeless
□ In between Housing □ Halfway House □ Homeless shelter

Community Health of Central Washington

Patient's Name: _____ DOB: _____ Medical Record #: _____

AUTHORIZATION AND CONSENT

Authorization and Consent

- **I consent that I am presenting at a clinic of Community Health of Central Washington for examination, diagnosis and /or treatment of my health, medical or dental condition.**
- **I give consent and authorize my provider/clinician(s) or his or her designees to order and/or perform all exams, tests, procedures and any other care deemed necessary or advisable for the diagnosis and treatment of my health, medical or dental condition.**
- **This consent is valid for each visit I make to a clinic of Community Health of Central Washington unless revoked by me in writing.**
- **I authorize and request my insurance company to pay directly to Community Health of Central Washington benefits otherwise payable to me.**
- **I understand that my medical and/or dental insurance carrier may pay less than the actual bill for services and that I am financially responsible for all charges for services rendered to me or my dependents, including the balance remaining after payment of possible insurance benefits, deductibles and applicable co-payments.**
- **I have received the Notice of Privacy Practices:**

Signature
Patient/Parent/Guardian _____

Date: _____

Community Health of Central Washington

Authorization to Release Patient Health Information

Patient Information (Please Print):

_____ ____/____/____

Last Name MI First Name Date of Birth

I Authorize:

Provider Name:
Facility Name:
City/ State/ Zip:
Phone/Fax:

To Release my protected health information to: (Check facility): ☐ All or specify which facility

Community health of Central Washington
Health Information Management Dept.
402 S. 12th Avenue │Yakima, WA
Phone : (509) 453-0722 Fax: (509) 452-5224

☐ Central Washington Family Medicine- Ph:(509) 452-4520
☐ Ellensburg -Ph:(509) 962-1414
☐ Naches- Ph:(509) 653-2235
☐ Yakima Pediatrics- Ph:(509) 575-0114
☐ Highland -Ph:(509) 673-0044

Records Requested

Healthcare information related to the following treatment or condition: _____

_____

Dates of Service: ___/____/___ through ___/____/___ **or** ☐Last year ☐Last 2 years ☐Immunizations

Purpose of Release: ☐ Personal ☐ Transfer of Care ☐Continuing Care
☐ Other (Please Specify): _____

By checking the boxes below I agree to release the following:

☐ I understand that if my record contains information concerning alcohol or drug abuse/treatment, mental health (including pain management or psychiatry records) or sexually transmitted diseases (including HIV/AIDS), such information will be **INCLUDED** in this disclosure. Sensitive records require specific patient authorization if the patient is an adolescent, therefore*, we request patients over age 12 years to also authorize release of information.*

☐ I want to **EXCLUDE** the following ____ Alcohol or drug abuse treatment
____ Mental Health
____ Sexually Transmitted diseases
____ HIV (AIDS)

Patient Rights:

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when the recipient has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health information to the above named person or organization. Release will expire in **90 days** from the date signed.

Please sign below:

_____ _____
Signature of Patient or legally authorized individual Date

_____ _____
Printed name *(if signed on behalf of the patient)* Relationship

_____ _____
*Minor patient's signature, if applicable Date