Community Health of Central Washington | Ellensburg

Greetings! This letter is to welcome you to Community Health Of Central Washington. Enclosed you will find our clinic registration packet.

This packet includes a Patient Registration Form, Health History Form and a Consent To Family & Other's form. Please use the Consent To Family & Other's form to specify any restrictions or permissions regarding communication between our staff and your family & other's.

What to bring to your first appointment:

- Insurance Card
- Photo ID
- Bottles of medications you are currently taking (this allows us to verify your medication, dosage & frequency).

Please check in with reception 15 minutes prior to your scheduled appointment time.

We look forward to providing you the best care possible. As our patient, you have the right to expect the following from us:

- We will respect your beliefs and values
- We will provide answers to your medical questions
- We will schedule Follow-Up appointments & Referrals as needed

We will expect the following from you:

- We request 24 hours notice to cancel an appointment. After 3 "NO SHOWS" you will be placed under sameday appointment status.
- Please provide 72 business hours advance notice for prescription refills
- Please be respectful of our staff members

Please Bring Completed New Patient Packet into our office Prior to Scheduling an Appointment.

Thank You for choosing CHCW! We look forward to providing your care!

Community Health
of Central Washington

Authorization to Release Patient Health Information
NEW PATIENT

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 98902
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

Community Health of Central Washington

Patient Registration Form

Patient's Information

Patient's Name: _____ DOB: _____ Medical Record #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Gender: _____ Email Address: _____
Patient's Marital Status: _____ □ Single □ Married □ Divorced □ Widow □ Separated
Patient's Work Status: □ Full Time □ Part Time □ Not Employed □ Self Employed □Student
□ Military □ Retired
If currently working – Employer Name: _____ Phone: _____

Guarantor's Information

Name: _____ DOB: _____ Gender: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone _____ Cell Phone: _____ Work Phone: _____

Insurance Information

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

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)** _____ **= Yearly Income**

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

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

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 □ Refused to Report/Unreported

If over 13 years old

Gender Identity:

□ Male □ Female □ Transgender Male/Female-to-Male □ Transgender Female/Male-to-Female
□ Other □ Choose not to disclose

Sexual Orientation:

□ Straight (not lesbian or gay) □ Lesbian or gay □ Bisexual □ Something else □ Don't Know □ Choose not to disclose

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 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 migrating to work in agriculture (farm work) because of disability or age (too old to do the work)? _____Yes _____No

For office use only : (YES to #1 and #2 = **Migrant)** (YES to #1 and NO to #2 = **Seasonal**) (YES to #3= **Aged/Disabled**) (NO to all three = **Non-farmworker**)

Patient's current living situation:

□ Own/Rent house or apartment (non-homeless) □ In between Housing □ Homeless
□ Halfway House/Transitional Housing □ 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, reviewed and understand the Patient's Rights and Responsibilities**
- **I have received the Notice of Privacy Practices:**

Signature
Patient/Parent/Guardian _____

Date: _____

Central Washington Family Medicine (509) 452-4520
Community Health of Central WA-Ellensburg (509) 962-1414
Highland Medical Clinic (509) 673-0044

Yakima Pediatrics (509) 575-0114
Naches Medical Clinic (509) 653-2235
Ellensburg Dental Care (509) 933-2400

Community Health of Central Washington

Consent to Disclose Information to Family or Others

Patient Name:_____ **DOB:**_____

Please review the following and **check all boxes that apply:**

☐ I, the above stated patient (or parent/legal guardian of the patient), authorize the staff of CHCW to leave a detailed voicemail at my primary phone number _____.

Please review the following and **check ONE of the options below:**

☐ I, the above stated patient (or parent/legal guardian of the patient), **DO NOT** authorize release of medical information other than what is provided by law.

OR

☐ I, the above stated patient (or parent/legal guardian of the patient), **authorize the following listed person(s)** to be involved in my medical care indefinitely. I authorize the above office to release:

Medical (Med.)	**Financial** (Fin.)
Verbal	Verbal
Written	Written
Paper Prescription	

Required

Please list below who is authorized to receive information from your records:			**Med.**	**Fin.**
Name_____	Relationship_____	Phone_____	☐	☐
Name_____	Relationship_____	Phone_____	☐	☐
Name_____	Relationship_____	Phone_____	☐	☐
Name_____	Relationship_____	Phone_____	☐	☐

I, the above stated patient (or parent/legal guardian of the patient), understand that if this form is not completed correctly, it is invalid and will be destroyed. I also understand that it is my responsibility to update information provided on this form as needed.

_____ _____

Patient Signature (or Parent/Legal Guardian & Relationship) **Date**

Community Health
of Central Washington

Patient Rights

Access to care
Individuals shall be given impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, cultural or spiritual values, disability or source of payment.

Providers of care
You have the right to know which physician or other practitioner is primarily responsible for your care. Your health care team may include other physicians, resident physicians, physician assistants, nurses, nurse practitioners, students and other health care providers.

Respect and dignity
You have the right to receive considerate, respectful care at all times and under all circumstances, with recognition of personal dignity, diversity, and religious or other spiritual preferences.

Privacy and confidentiality
You have the right, within the law, to personal and informational privacy, as demonstrated by the following rights:

- To expect that any discussion or consultation involving your care will be conducted discreetly and that individuals not directly involved in your care will not be present without permission.
- To have the medical record accessed only by individuals for legitimate business purposes and as permitted under law.
- To expect all communications and other records pertaining to care, including the source of payment, be treated as confidential.

Charges
You have the right to receive a copy of a reasonably clear and understandable itemized bill and have the charges explained upon request. You have the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for your care. You have the right to receive, upon request and prior to treatment, a reasonable estimate of charges for your care.

Consent
You have the right to reasonable, informed participation in decisions involving your health care. To the degree possible, this should be based on a clear and concise explanation of your condition and planned procedures, including benefits, the possibilities of any risk, problems related to recuperation and probability of success. Before undergoing any procedure, you or your legal representative will voluntarily provide informed consent. You will be informed if medically significant alternatives for care or treatment exist.

Refusing treatment
You or your legal representative may refuse treatment to the extent permitted by law. When refusal of treatment by you or your legal representative prevents the provision of appropriate care in accordance with professional standards, our relationship with you may be terminated upon reasonable notice.

Right to Access your Medical Record
You have the right to review and receive your medical records as subject to state laws and CHCW policies.

To share concerns or suggestions
You have the right to share concerns or suggestions without fear, repercussion or discrimination.

Community Health
of Central Washington

Patient Responsibilities

Respect and consideration

You are responsible for being considerate of the rights of other patients and clinic staff. You are responsible for being respectful of the property of others and of the clinic. You understand that any abusive or disrespectful behavior could result in your dismissal from Community Health of Central Washington. This includes:

- Not using profanity or foul language
- Not smoking
- Not carrying any weapons including permitted firearms into any CHCW building
- Not acting aggressively, disruptive or threatening
- Not taking video or pictures while in any CHCW building without staff consent
- Controlling the noise level of yourself and those with you

Providing information

As a patient, you are an integral part of the healthcare team. Therefore, you are responsible for:

- Participating in your care and health care decisions
- Providing, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, allergies and other matters relating to your health
- Reporting unexpected changes in your condition to the responsible practitioner
- Communicating whether you clearly understand your plan of care and what is expected of you

Charges

You are responsible for assuring that your financial obligations for health care received are fulfilled as promptly as possible.

Compliance

You are responsible for following the treatment plan recommended by the practitioner primarily responsible for your care. This may include following the instructions of nurses and staff as they carry out your plan of care, implement the responsible practitioner's orders and enforce applicable clinic rules and regulations. You are responsible for keeping appointments and for notifying your clinic when you are unable to do so.

Community Health of Central Washington | Ellensburg

No Show Policy

Dear Patient,

We would like to take a moment to welcome you to our practice. We are very pleased that you have chosen Community Health of Central Washington-Ellensburg to be your primary care provider and look forward to providing you with exceptional health care.

In an effort to maximize the time your provider spends with you and to minimize your wait time, please review the following No Show Policy:

- Our clinic requests that patients provide us with 24 hour notification if the appointment needs to be cancelled or rescheduled. With 24 hour notice, we then have enough time to schedule another patient in the appointment slot.
- Of course, we also understand that unforeseen events sometimes occur, so in emergency situations, we request at least one hour prior notification should you be unable to make your appointment.
- Should you no show for three appointments within one rolling calendar year, you will be required to call by 3pm the day before your scheduled appointments to confirm you will be here.

We value our patients and want to continue to provide you with quality care. Should you have any questions or concerns, please feel free to contact our office at (509) 962-1414.

Sincerely,

Community Health of Central Washington-Ellensburg