Patient Profile

PATIENT INFORMATION

Name: _____ Pt ID#/ MRN: _____ Sex: ( ) M ( ) F

Preferred: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Marital Status: ( ) Married ( ) Single ( ) Divorced

City, State: _____ Primary Physician : _____

Phone: _____ ( ) Home ( ) Work ( ) Other Preferred Language: _____

Phone: _____ ( ) Home ( ) Work ( ) Other Contact By: _____

Phone: _____ ( ) Home ( ) Work ( ) Other

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

Veteran Status: ( ) Veteran ( ) Non-Veteran EMERGENCY CONTACT

Agricultural Worker ( )Non- Agricultural ( )Seasonal ( )Migrant _____

Status: ( )Employed Year Round ( )Retired Farmworker Family Size/ Income *(Voluntary for all patients for grant)*

Family Size: _____ Annual Income: _____

GUARANTOR Phone: _____

( ) Same as Patient Alt Phone: _____

Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____

_____

City, State: _____

PRIMARY INSURANCE Relationship to Primary

( ) Same as Patient ( ) Same as Guarantor ( ) Other Insured/ Guarantor: _____

Insured Party: _____ Social Security #: _____

Insured Phone: _____ Insured ID: _____

Company: _____ Policy Group: _____

Date of Birth: _____

SECONDARY INSURANCE Relationship to Primary

( ) Same as Patient ( ) Same as Guarantor ( ) Other Insured/ Guarantor: _____

Insured Party: _____ Social Security #: _____

Insured Phone: _____ Insured ID: _____

Company: _____ Policy Group: _____

Date of Birth: _____

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, dental, nutrition, or behavioral health 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 or dental services rendered to me or other persons 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 balances due to BRCHS. Payment of deductibles and copayments are expected each time a service is provided.

Signature: _____ Date: _____

BLUE RIDGE HEALTH

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.

You may share my PHI with the following persons:

☐ Give information to family members (include name/s) _____
☐ Give information to other/s (include name/s) _____

I will be contacted in the following manner:

Home Telephone Number _____

BRCHS will leave messages, including medical information, with call-back number at this number and on voicemail or answering machine, if applicable.

☐ Do not contact me at home telephone number.

Cell Phone Number _____

BRCHS will leave messages, including medical information, with call-back number at this number and on voicemail, if applicable.

☐ Do not contact me on my cell phone.

My primary contact number is my: ☐ Home telephone ☐ Cell phone

BRCHS will contact you at your primary contact number for appointment reminders unless otherwise noted above.

Written Communication:

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

☐ Mail information to other address _____

☐ Do not send written information to me.

Fax information to the following number: _____

Email: **BRCHS can communicate with me through email: _____ @ _____**

Patient Authorization Form for email on the reverse side must also me 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/ Witness Signature _____

PATIENT AUTHORIZATION TO USE E-MAIL 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 ("E-mail"). I acknowledge and understand that such E-Mail 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 sent to me and will take all reasonable measures to protect my privacy, the E-Mail messages sent to me are not encrypted and travel over the Internet and, as a result, there is a risk that the E-Mail will be intercepted and read by third parties to whom the E-Mail is not directed. In authorizing BRCHS to send me E-Mail, I assume the foregoing risk.

I understand that E-Mail is 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, certain employees and agents of BRCHS may have access to my e-mail address and E-Mail 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 communications sent from or stored on my computer or information system, including, but not limited to, protecting access to any E-Mail stored on my computer or information system, implementing security measures when delivering E-Mail from my computer 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 for BRCHS business purposes and that it will not sell, transfer or otherwise disclose my e-mail address 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 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.

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

A photostatic 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: _____

Permission to Photograph

I agree that Blue Ridge Community Health Services, Inc. (BRCHS) may take a digital photo of me.

I understand that:

- The photo will be stored permanently in my medical record.
- The photo will be used to identify me when I come to BRCHS for care.
- The photo will be stored securely to protect my privacy.
- The photo will NOT be used outside of BRCHS, unless I (or my legal representative) give my permission in writing.
- BRCHS will own the photo. I can look at the photo or get copies, if I (or my legal representative) sign a release form.

Signature of patient (or person authorized to sign for patient) _____

Relationship to patient_____Date _____

☐ I decline_____Date_____

BLUE RIDGE HEALTH

APPLICATION FOR DISCOUNT SERVICES SLIDING FEE SCHEDULE

PATIENT NAME _____ **HOME/ CELL NUMBER** _____

☐ **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.**

Patient Signature _____ Date _____

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical, behavioral health, and/or dental needs. **This information will not be used to withhold or deny services to you**.

1. Are you covered under Medicaid, Medicare and/or any other insurance? Yes No
2. If you have private insurance, what is your annual deductible, per family member? $_____
3. Have you or your dependents ever applied for or been denied for Medicaid or Medicare? Yes No
4. Would you like to apply or re-apply for Medicaid today? Yes No
5. Are you unemployed? Yes No
6. Are you too sick to work or are you disabled? Yes No

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

Name	Date of Birth	Relationship to Head of House	Insurance or Medicaid?
		Head of Household	**Yes or No**
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No

INCOME VERIFICATION

Please enter your **gross income** (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, bank verification, a letter from the employer stating wages earned or proof of unemployment.

If there is **no income to report, or if you do not want to comply with documentation requirements**, you must complete the reverse side of this application.

HOW ARE YOU PAID?	AMOUNT?	CIRCLE ONE?
Work Wages	**$**	**Weekly /Bi weekly /Other**
Cash Wages	**$**	**Weekly /Bi weekly /Other**
Disability	**$**	**Weekly /Bi weekly /Other**
Social Security	**$**	**Weekly /Bi weekly /Other**
Unemployment	**$**	**Weekly /Bi weekly /Other**
Worker's Comp	**$**	**Weekly /Bi weekly /Other**
Child Support	**$**	**Weekly /Bi weekly /Other**
Other Income	**$**	**Weekly /Bi weekly /Other**

Office Use Only

Staff Signature:_____

Verifies Wages are calculated in PM System

Date: _____

Patient Advised of Discount Rate: _____

Initials

Audit Stamp:

PLEASE REFER TO THE CURRENT BRCHS SLIDING FEE DISCOUNT SLIDE SCHEDULE

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify the facility. 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.

Patient Signature_____ Date_____

Declination Statement (for Patient's Who Do Not Want to Comply with Sliding Scale Requirements)

Because you do not wish to apply or comply with the requirements to apply for our sliding scale discount, you are choosing to be a self pay patient. This means that you will pay ***$75.00*** up front at the time of service and you will be responsible for any and all balances due after the provider's charges for your visit are entered. You will also be responsible for any lab and/or x-ray charges for today's visit. Any discount for office charges or lab charges are not applicable and you will not be allowed to receive a discount for these charges in the event that a future sliding scale application is completed.

Patient Signature_____ Date_____

COMPLETE BELOW FOR Self-Declaration of Income

Please complete the information below only ***if you have no other way to document your income***. All of the boxes below must be checked and all the questions answered. Failure to complete this information will result in in denial of your application for a sliding scale discount.

- ☐ I get paid in cash.
- ☐ I do not get pay checks.
- ☐ I do not get pay stubs.
- ☐ I cannot get a letter from my employer. Explain why: _____

_____

My cash income is $_____ How often?: ☐Weekly, ☐Bi-Weekly, ☐Monthly, ☐Other:_____

Current Employer: _____

Patient Certification Statement

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_____

Employee Certification Statement

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used best efforts to obtain other posible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature_____ Date _____

Medicare Secondary Payer Form

DATE_____ PATIENT NAME _____

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/ injury due to an automobile accident, liability accident, or Workman's Compensation? ☐ Yes ☐ No

2. Is illness covered by the Black Lung Program or Veterans Administrationprogram? Yes ☐ No ☐

3. If under 65, are you a renal analysis patient in your first 30 monthsof Medicare entitlement? ☐ Yes ☐ No

4a. If under age 65, is your Medicare coverage dueto disability? Yes No ☐ ☐

4b. Is patient covered by a large group health plan through patient's employer or spouse's current employer? ☐ Yes ☐ No

5. If 65 and over, is patient covered by Employer Group Health Plan through patient's or spouse's current employer? ☐ Yes ☐ No

Registrar Notes:

A. If patient responds "no" to questions 1-5, Medicare isprimary.

B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must beobtained.

Name of Insurance Company _____

Address of Insurance Company _____

_____

Name of Policy Holder _____

Policy Number _____

Policy Holder's Employer Name _____

Policy Holder's Employer Address _____

Date of Accident (ifapplicable) _____

Patient Signature _____

BLUE RIDGE HEALTH

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name:_____

DOB: _____

Social Security Number:_____Centricity ID: _____

I am either the person named above or someone who can legally act for the person.

I give permission for _____

Complete Name of Person, Agency, Facility, or Program requesting &/or receiving the information. Do not abbreviate. **Include Address, Fax #, or EMAIL, if needed.**

to share with _____

Complete Name of Person, Agency, Facility, or Program requesting &/or receiving the information. Do not abbreviate. **Include Address, Fax #, or EMAIL, if needed.**

The following protected health information:

Complete health record ☐	Discharge Summaries ☐	Clinical lab reports ☐	History & physical ☐
Consultation Reports ☐	Radiology reports ☐	Clinical office notes ☐	Medication history ☐
Problem Lists ☐	Medication List ☐	Physician Notes/Summaries ☐	

For the purpose of: ☐ Permanent Transfer to another provider

☐ Consultation with: _____

☐ Other: _____

Covering periods from:

1) The period from_____to_____
2) Date(s) of service: _____

Sensitive information may be included in your protected health information. By my indication below, next to each type of sensitive information listed, I am agreeing that sensitive medical information of this type may be shared.

Pregnancy ☐	Communicable Disease Treatment ☐	Alcohol & Drug Abuse Treatment ☐
Family Planning ☐	Psychological Evaluation ☐	Mental Health Treatment Records ☐
Sickle Cell Anemia ☐	Gene-related impairments ☐	HIV/AIDS Treatment ☐

You need to know

- Federal and state HIPAA Laws tell us how to protect the privacy of your health information. We will protect your health information while it is at Blue Ridge Community Health Services, Inc.
- When we share information we cannot guarantee that the privacy of your information will be protected, if they are health care providers they are required by law to protect the health care information. *We may send the requested information above via fax, USPS mail, or electronically via encrypted email to your new provider.*
- Your authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 6 months from the date signed, or until the following event or condition:

  _____

  _____

Patient Signature_____Print Name_____Date _____

If you are not the patient, please state your authority to act for the patient listed above:

_____

Staff (Witness) Signature_____Date _____

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Staff Initials:

Date disclosure completed_____By_____Sent Via: ☐ USPS Mail ☐ Fax ☐ Encrypted Email

Date this authorization was revoked: _____

BLUE RIDGE HEALTH

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 Name Date of Birth Date

Patient Signature Date

Witness Signature Date