Christ Community HEALTH SERVICES

Consent for Evaluation and Treatment

Christ Community Health Services (CCHS) is dedicated to providing primary care, dental and mental health services. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. CCHS patients may be referred to providers from other health care specialties within the CCHS treatment team.

Patients are seen by appointment, except in emergencies. Patients must call in advance if they cannot keep their appointment.

Information about a patient will NOT be given to anyone outside CCHS, including family and friends, unless the patient (parent or legal guardian, if a minor) gives written permission. However, we may release patient information to others without the patient's permission if: 1) the patient poses a threat to him/herself or others; 2) the patient is unable to protect him/herself from risk of harm; 3) the patient is in the legal custody of a government agency or facility; 4) there is evidence or suspicion of child abuse; 5) the patient's clinical records are requested under court order or 6) the patient is referred to a collection agency in order to collect on an overdue account.

There are fees for all services and patients are asked to pay on the day they are seen. Health insurance policies may cover a portion of the fees and staff will help the patient in making claims. Patients are asked to tell CCHS staff about changes in financial status.

The professional staff of this facility will depend on statements made by the patient, the patient's medical history and other information to evaluate his/her condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members except in cases where family planning or obstetrical services are provided.

Health professions are not exact sciences and no guarantees are made concerning the course of treatment proposed by the provider. Any questions about the benefits, risks, available options or the limits of confidentiality should be directed to the treatment staff.

In treating patients, studies including laboratory tests, X-rays, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff.

FTCA Deeming Notice: This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals, including, but not limited to employees, providers, certain contractors and volunteers.

I understand, that if I am 13 years of age or older, I may consent for family planning or obstetrical services; if I am 16 years of age or older, I may consent for mental health services; and if I am 18 years of age or older, I may consent for all other health services; otherwise my parent or legal guardian will need to consent for services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask and agree to evaluation and treatment for myself and/or my child(ren), including any studies or procedures that CCHS professional staff decides are necessary.

____ ________________

Patient Name (*please print*) Date of Birth

______________________________ __________ __________________________ __________

Signature of Patient or Guardian Date Signature of Witness Date

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last) (First) (Middle) (Jr, Sr, etc.)

Gender	**Marital Status**	**Date of Birth**	**Social Security Number**
☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated	/ /	

What is your race?
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ More than one race ☐ Other

What is your Ethnicity?	**What is your primary language?**	**Who is your provider at CCHS?**
☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ English ☐ Spanish ☐ Other___________________________	

Full Address (Street or P.O. Box) (City) (State) (Zip)
Apt.#:

Home Phone Number	**Cell Phone Number**	**Work Phone Number**	**Email Address**
( )	( )	( ) Ext.	

Please be prepared to present your insurance card, photo identification and proof of income documentation, if necessary.

RESPONSIBLE PARTY *(Complete if different from above)*

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Foster Parent ☐ Guardian ☐ Child ☐ Grandchild ☐ Other_______________________________

Name of Responsible Party (Last) (First) (Middle) (Jr, Sr, etc.)

Date of Birth	**Gender**	**Social Security Number**	**Marital Status**
/ /	☐ Male ☐ Female		☐ Single ☐ Married ☐ Divorced ☐ Separated

Home Phone Number	**Work Phone Number**	**Cell Phone Number**	**Email Address**
( )	( ) Ext.	( )	

Full Address (Street or P.O. Box) (City) (State) (Zip)
Apt.#:

Type of Insurance (BCBS, UHC, etc.)	**Policy Holder ID** (Subscriber ID)	**Group #**	**Subscriber Name**	**Relation to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other________________

Please provide any additional insurance coverage/information you may have to the registration representative.

ADDITIONAL INFORMATION

How many dependents are in your home, including you?	**How often are you paid?** ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually	**What is your gross income (before taxes) during this time period?** $	You may qualify for the Sliding Fee Discount Program, even if you have insurance. Please complete the application in this packet.

Are you Homeless?	**If Homeless, what is your Living Situation?**	**Are you a Veteran?**
☐ Yes ☐ No	☐ Shelter ☐ Transitional ☐ Staying with Family or Friends (Doubling Up) ☐ Street ☐ Other____________________	☐ Yes ☐ No

Are you an Agricultural Worker?	**How did you hear about CCHS?**
☐ No ☐ Yes (If Yes, which are you: ☐ Migrant ☐ Seasonal)	☐ Friend/Family ☐ Health Fair ☐ Other____

Primary Pharmacy (Name) (Address) (Phone) (Fax)

Gender Identity ☐ Choose not to disclose	**Sexual Orientation** ☐ Choose not to disclose
☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female	☐ Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Other

APPROVED HIPAA CONTACTS

Keeping our patient's information private is important and by default we will only disclose information related to your Billing information and/or Medical Conditions to the **patient or legal guardian**. However, if you would like to add other contacts that you would like for CCHS to disclose this information please complete the fields below and select the appropriate checkboxes noting your approval for each person listed. Also, please note those you would like to serve as your **Emergency Contact.**

Contact Name	**Relationship to Patient** *(Spouse, Child, etc.)*	**Contact Phone Number** ( )	☐ Billing Information ☐ Medical Conditions/information ☐ Emergency Contact
Contact Name	**Relationship to Patient** *(Spouse, Child, etc.)*	**Contact Phone Number** ( )	☐ Billing Information ☐ Medical Conditions/information ☐ Emergency Contact
Contact Name	**Relationship to Patient** *(Spouse, Child, etc.)*	**Contact Phone Number** ( )	☐ Billing Information ☐ Medical Conditions/information ☐ Emergency Contact

The duration of this authorization is indefinite unless otherwise changed in writing. CCHS understands that requests for health information from persons not listed on this form will require your specific authorization prior to the disclosure of any health information.

PREFERRED METHODS OF COMMUNICATION

Keeping you informed of your care is very important to us. Therefore, we would like to convey information in the form that suits you. Please share with us your preferred method of communication for the instances noted below:

For Health Information:	**For Health Information, if your selection is by phone, please select one of the following:**	**For Follow-Up Reminders:**
☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text Message ☐ Mail ☐ Email ☐ Guardian ☐ Approved Contact ☐ Patient Portal	☐ Leave a message with the detailed information ☐ Leave a message with a call-back number only	☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text Message ☐ Mail ☐ Email ☐ Patient Portal

PATIENT REGISTRATION FORM

ADVANCED MEDICAL DIRECTIVE & STATEMENT OF PATIENT RIGHTS	
Please check all of the boxes that fit your status.	
☐ I have a Living Will or Advanced Directive ☐ I have Durable Power of Attorney for health care ☐ I do not have any type of Living Will or Advance Directive ☐ I desire to create a Living Will or Advanced Directive with my provider ☐ I choose not to disclose	☐ Patient is unable to sign Registration Representative:_______________________ Date:____________
Please read the following statements and place your initials in the boxes below.	
I understand I am not required to have a Living Will or Durable Power of Attorney for Healthcare in order to receive medical treatments at this healthcare facility.	**Initials**
I understand this healthcare facility will follow my written wishes in the event that I cannot speak for myself.	**Initials**

AUTHORIZATION AND ASSIGNMENT

I do hereby voluntarily consent to health care at Christ Community Health Services (CCHS). I hereby authorize all physicians, dentists, pharmacists, behavioral health providers and their assistants including Physician Assistants, Nurse Practitioners and Social Workers employed by CCHS to use such diagnostic and treatment procedures they deem necessary for proper medical management and treatment. I understand that Physician Assistants, Nurse Practitioners and Dental Hygienists are not licensed physicians/dentists and may help provide medical/dental care only under the supervision and direction of a licensed physician or dentist. I also assign the claim payments to be made payable to CCHS. I agree to the release of information to Medicare, TennCare and third party payors. I understand that some of the services that may be ordered may not be covered under Medicare, TennCare and other insurance and that I am responsible for any amount that is not paid. THIS AUTHORIZATION AND ASSIGNMENT IS A PERMANENT ONE-TIME SIGNATURE WHICH WILL REMAIN ON FILE AND WILL BE USED FOR FUTURE CLAIMS. I MAY REVOKE IT AT ANY TIME BY WRITTEN NOTICE. Further, I agree to all consents noted in the above application and approve of the contacts listed in an effort to protect my health information.

Signature of Patient/Responsible Party: ____ **Date:** _______________________

Signature of Witness (Registration Representative):___________________________________ **Date:** _______________________

Christ Community Health Services, Inc.
Notice of Privacy Practices (Summary Notice – CCHS's Copy)

PLEASE REVIEW THIS PAGE, SIGN BELOW AND **RETURN THIS PAGE TO A REGISTRATION REPRESENTATIVE.**

If you would like to review the Long Form Notice, please request one from a Registration Representative. Please keep the Long Form Notice and take it home with you. You may review it now or later. Let us know if you have any questions after reviewing it.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit a health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. The doctors and staff of Christ Community Health Services, Inc. (CCHS) use and maintain this health information relating to the care you receive.

The Long Form Notice contains information to help you understand what is in your health record and how your health information is used. This helps you ensure the accuracy of such information and lets you better understand who, what, when, where and why others may have access to your health information.

Please sign below to acknowledge your receipt of this Notice:

_________________________________ _________________________________ ________________

Patient Name (*please print*) Signature of Patient or Personal Representative Relation to Patient

(For office use only) : If patient did not acknowledge receipt of Notice, please explain: ____

____

Staff Member Name:____ **Date**:______________________

GRIEVANCE FORM INSTRUCTIONS

Christ Community™
HEALTH SERVICES

As a patient of Christ Community Health Services, you have the right to voice any concerns or complaints regarding your care. The following steps will outline to you how to navigate this process and what to expect while completing a grievance or complaint. You will be shown throughout every step that your healthcare is our top priority in meeting your specific needs.

Step 1:

Should you have a complaint or grievance regarding your care, you may alert the Site Manager at your clinic. The Site Manager will attempt to resolve the complaint with the particular service area where the complaint or grievance exists. From there the Site Manager will take steps to meet your needs and healthcare requests internally and locally within the clinic. If this does not meet your needs, you may take the next step.

Step 2:

After a complaint is made to the Site Manager at your clinic and efforts have been unsuccessful to resolving the complaint, you may submit a formal grievance to Administration. This may be done in writing using a form for this purpose. Alternatively, you may contact the Administrative contact at (901) 842-1872.

Step 3:

The Administrative contact documents the formal complaint into the complaint system and assigns it to the appropriate senior leader. Typically, the complaint is resolved within seven (7) days. Some cases may take longer to resolve due to extenuating circumstance. Risk management oversees the process to ensure that the senior leader responds in a timely manner and communicates with you as to the resolution.

Please sign below showing that you have been informed of the process with regard to how to make or lodge complaints/grievances. A copy of this notification will be given to you and also placed into the chart.

______________________________ ____________________

Patient Signature Date

______________________________ ____________________

Staff Signature Date

HEALTH HISTORY FORM

Name ________________________ **Date of Birth** _______________ **Today's Date** _______________

MEDICATIONS ***(including herbals, birth control and over-the-counter meds)*** ☐ None

	Name	Dose	Taking	Not Taking	Need Refills
1			☐	☐	☐
2			☐	☐	☐
3			☐	☐	☐
4			☐	☐	☐
5			☐	☐	☐
6			☐	☐	☐
7			☐	☐	☐
8			☐	☐	☐
9			☐	☐	☐
10			☐	☐	☐
11			☐	☐	☐
12			☐	☐	☐
13			☐	☐	☐
14			☐	☐	☐
15			☐	☐	☐

CURRENT AND PAST MEDICAL PROBLEMS ***(check all that apply)*** ☐ None

☐ Anxiety / Depression
☐ Asthma
☐ Currently Pregnant
☐ Currently Nursing
☐ Diabetes
☐ High Blood Pressure
☐ Allergies or Hay Fever
☐ Artificial joint or bone replacement
☐ Blood clots, DVT, Pulmonary Embolism
☐ Bone, muscle or joint disorder
☐ Cancer or Leukemia
☐ Endocarditis
☐ Emphysema, COPD, Chronic Bronchitis
☐ Enlarged Heart or CHF
☐ Epilepsy, Seizures, Convulsions
☐ Headaches or Migraines
☐ Heart Attack or Chest Pain
☐ Heart Valve Defect or Surgery
☐ Heart Bypass, Angioplasty, Stents
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis, Jaundice or Liver Disease
☐ HIV positive or AIDS
☐ Heart Pacemaker or Defibrillator
☐ Kidney Dialysis
☐ Schizophrenia / Bipolar
☐ Stroke
☐ Sickle Cell Disease or Trait
☐ Transplanted Organ

Other: ____

____

____

ALLERGIES ☐ None

☐ Any metals (nickel, mercury, etc.)
☐ Dental metals (resins, amalgam, etc.)
☐ Food allergies
☐ Iodine or shellfish
☐ Latex or rubber
☐ Red Dye
☐ ______________________
☐ ______________________
☐ ______________________

DRUG ALLERGIES ☐ None

☐ Aspirin
☐ Analgesics or pain medications
☐ Barbiturates, sedatives or sleeping pills
☐ Codeine
☐ Keflex or celphalosporins
☐ Lisinopril or other "-pril"
☐ Mycins (e.g. erythromycin, azithromycin, etc.)
☐ Novocaine or other local anesthetics
☐ Penicillin or amoxicillin
☐ Sulfa drugs
☐ ______________________
☐ ______________________

SURGERIES *(include eyesurgery and anyreactionstoanesthesia)* ☐ None

Month / Year	Type of Surgery

HOSPITALIZATIONS / ER VISITS ☐ None

Month / Year	Reason for hospital stay / ER Visit

HEALTH HISTORY FORM

FAMILY HISTORY *(check all that apply)*

☐ None / Unknown

Family Member	Still Living?	Diabetes	High Blood Pressure	Heart Disease	Cancer	Asthma	Birth Defect	Mental Illness	Substance Abuse
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother's Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother's Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father's Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father's Father	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other: ____

____

TOBACCO USE / SMOKING

Are you currently a smoker?	☐ Yes	☐ No
Do you smoke every day?	☐ Yes	☐ No
How many cigarettes per day?	☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30	
How soon after waking do you smoke?	☐ <5 min ☐ 6-30 min ☐ 31-60 min ☐ 60+ min	
Are you:	☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit	

Do you use other forms of tobacco? *(check all that apply)*	☐ fine cut ☐ loose leaf ☐ plug tobacco ☐ twist tobacco ☐ e-cigarettes	☐ cigar ☐ pipe ☐ snuff ☐ moist powdered tobacco
Have you ever smoked?	☐ Yes	☐ No
How long since you last smoked?	☐ <1 month ☐ 3-6 months ☐ 7-12 months	☐ 1-5 years ☐ 6-10 years ☐ >10 years
Did you use another form of tobacco in the past?	☐ Yes ☐ No ☐ Don't Know	

ALCOHOL USE

Did you have a drink containing alcohol in the past year?	☐ Yes	☐ No
If yes, how often did you drink?	☐ monthly or less ☐2-4 times per month ☐2-3 times per week ☐4+ times per week	
How many drinks did you have on a typical day when you were drinking in the past year?		

SUBSTANCE USE

Have you used any non-medical drugs in the past 12 months?	☐ Yes	☐ No
If yes, which drug(s): ______ Are you still using?	☐ Yes	☐ No
How many months ago did you last use?	☐ <6 months ☐6-12 months ☐12-24 months ☐24+ months	
Are you in a treatment program?	☐ Yes	☐ No
Are there any children under the age of 18 at risk in the home?	☐ Yes	☐ No

SEXUAL HISTORY

Have you had sex?	☐ Yes, within last month ☐ Yes, in the past ☐ Never been sexually active	
Do you have sex with?	☐ Men ☐ Women	☐ Both ☐ Neither
Number of sexual partners in your lifetime?		
Age when you first had sex?		

Are you having sexual problems?	☐Yes	☐ No
Do you have any history of sexually transmitted infections?	☐Yes	☐ No
If yes, which infections?	☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ HIV	☐ Herpes ☐ Syphilis ☐ Trichomonas ☐ __________

Are you dealing with any type of abuse or violence?	☐ Yes	☐ No

If yes, which type(s): ☐ Physical ☐ Sexual ☐ Verbal ☐Emotional ☐ Neglect ☐I prefer not to disclose

HEALTH HISTORY FORM

HOUSEHOLD INFORMATION			
How many adults are in the household?		How many children are in the household?	
What is your education level?	☐ Some high school ☐ High school ☐ Some College ☐ Associates ☐ Bachelor's ☐ Graduate		
What is your employment status?	☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Disabled		
Occupation:		Employer:	

POTENTIAL BARRIERS TO CARE		
Were you unable to afford prescribed medication in the past year?	☐ Yes	☐ No
Did a lack of transportation cause you to miss a medical appointment in the past year?	☐ Yes	☐ No
Is any person preventing you from getting medical care as recommended?	☐ Yes	☐ No
Do you have difficulty reading on your own?	☐ Yes	☐ No
Do you face any of these communication issues?	☐ Hearing Impaired ☐ Vision Impaired ☐ Cognition Issues	
Are you aware of the medications you are taking and their potential side effects?	☐ Yes	☐ No
Are you able to follow your medication instructions?	☐ Yes	☐ No
Are you able to understand the results of your blood test, x-rays and other medical procedures?	☐ Yes	☐ No
Has your physical or emotional health limited your social activities?	☐ Yes	☐ No

NUTRITION AND EXERCISE INFORMATION		
How much caffeine do you have per day?	☐ None ☐ 1-2 cups ☐ 2-3 cups ☐ 3-4 cups ☐ 5+ cups	
How many servings of fruits and vegetables do you eat each day?	☐ < 1 serving ☐ 1 serving ☐ 2 servings ☐ 3 servings ☐3+ servings	
Do you usually drink 2 or more sugar sweetened beverages per day?	☐ Yes	☐ No
Do you exercise?	☐ Yes	☐ No

HEALTH CARE HOME		
Have you seen your dentist for a regular checkup in the last 12 months?	☐ Yes	☐ No
What is the name of your regular dentist?	☐ CCHS Dentist: ______________________ ☐ Other: ______________________	
What is the name of your Primary Care Provider (PCP)?		

SPIRITUAL HEALTH – WE WOULD LOVE TO PRAY FOR YOU

How would you like for us to pray for you?

____

Patient Signature: ____ Date:_____________

CCHS Provider Signature: ____ Date:_____________