REGISTRATION FORM

Today's Date:	**PCP:**

PATIENT INFORMATION

Patient's Legal Last Name:	**First:**			**Middle:**
Previous Names Used/Alias:	**Birth Date:** / /	**Age:**	**Social Security #:**	**Sex at Birth:** ❑M ❑F ❑Other
Home Phone:	**Cell Phone:**		**Work Phone:**	
Mailing Address:	**City:**	**State:**	**Zip:**	
E-Mail Address:				

Race:
❑Alaska Native
❑Pacific Islander
❑Native Hawaiian
❑Asian
❑White
❑American Indian
❑Black or African American
❑Unknown
❑Choose not to disclose

Ethnicity:
❑Hispanic ❑Not Hispanic
❑Unknown

Sexual Orientation:
❑Lesbian or gay
❑ Straight (not lesbian or gay)
❑ Bisexual
❑ Something else_____
❑ Don't know
❑Choose not to disclose

Gender Identity:
❑Female
❑Male
❑ Transgender Female / Male-to-Female
❑ Transgender Male / Female-to-Male
❑Other: _____
❑Choose not to disclose

Preferred Pronoun:
❑ she/her/hers
❑ he/him/his
❑ they/them/theirs
❑ patient's name
❑ decline to answer
❑ unknown

EMPLOYMENT STATUS

Employment Status:
❑ Child
❑Full time
❑Part time
❑Not employed
❑On Active Military Duty
❑Retired
❑Seasonal
❑Self-Employed
❑Student Full-Time
❑Student Part-Time

Are you a Veteran?
❑Yes ❑No

Number of Family Members:	**Monthly Income (before taxes) $**

LANGUAGE

What language do you speak at your home: ❑English ❑Spanish ❑Other: _____	**Interpreter Needed:** ❑Yes ❑No **Preferred:** ❑Male ❑Female ❑No Preference

RESPONSIBLE PARTY

If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Parent/Legal Guardian Responsible for Bill:	**Birth Date:** / /	**Social Security # of Parent/Legal Guardian:**

Mailing Address: ❑ Same as above	**City:**	**State:**	**Zip:**
Phone Number:	❑Home ❑Mobile ❑Work		

(turn page over to finish reading and sign this registration form)

ADDITIONAL INFORMATION

Homeless Status:

- ❑Not Homeless
- ❑At Risk for Homeless
- ❑Transitional Housing
- ❑Living with Others
- ❑Homeless, Unknown Shelter
- ❑Living in Shelter
- ❑Street, Camp, Bridge
- ❑Currently Not Homeless, Was in the Last 12 Months

Farm Work Recognition: Are you or someone in your household involved in a type of farm work that may include: soil prepping, planting, picking, cleaning, sorting, packing, Christmas tree farming?

❑Yes ❑No

❑ Migrant – You or a member of your household has established a temporary home in order to do farm work
❑ Seasonal – You or a member of your household do farm work that only happens at certain times throughout the year

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neighborhood Health Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

FOR OFFICE USE ONLY

Initials for Special Confidentiality:_____ Screen By: _____ Total Income: $ _____

TITLE X: Clients pay _____ % per sliding fee scale for non-FPEP covered service.

Address Verification: □ Yes Date/Initials_____ □ Patient declined confidentiality

COMBINED CONSENT FORM

Patient Name _____ *Patient Date of Birth (DOB)* _____

TREATMENT AND FINANCIAL

I authorize treatment of the person named above and accept financial responsibility for all treatment, including any necessary or recommended vaccines provided. I authorize Neighborhood Health Center to provide to my insurance companies all information necessary to process insurance claims and assign Neighborhood Health Center all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy or scanned image of this authorization shall be considered as valid as the original.

ACKNOWLEDGMENT OF HIPAA NOTICE

I acknowledge receipt of Neighborhood Health Center's Notice of Privacy Practices.

PATIENT CENTERED PRIMARY CARE HOME CONSENT

Your primary care home will; better coordinate our care to help get you the services you need, listen to your concerns and answer your questions, offer after-hours help and alternatives to the emergency room, help you play an active role in your health. I have read and understand the information on Patient Centered Primary Care Home and consent to be a part of the Neighborhood Health Center Medical Home.

REPRODUCTIVE HEALTH SERVICES

When seeking reproductive health services from Neighborhood Health Center I understand that I am receiving these services voluntarily.

I understand that these services may include:

- Reproductive health counseling on birth control, getting pregnant, healthy pregnancies, and other subjects as needed;
- Providing a birth control method;
- A provider visit for a prescription and maybe a physical exam;
- Testing and/or treatment for sexually transmitted infections (STIs);

(turn page over to finish reading and sign this consent form)

- Testing for cervical cancer, pregnancy and/or other health problems; and
- Referrals to other services, if needed.

I understand that all services will be explained and I can ask questions.

I understand I may be given information about birth control methods. I can ask questions and refuse any birth control method I do not want to use.

I understand that I won't be refused care if I owe money from other visits.

I understand these services do not include 24-hour care, and in case of a medical emergency, I will need to go to an emergency room and pay its costs.

I understand that the services I receive and my medical records are private, except:

- If a judge issues a subpoena for my records. Neighborhood Health Center is required by law to give the records to the court.
- If I have reportable disease, Neighborhood Health Center will be required to report it to Oregon State Public Health.
- The State of Oregon requires all Neighborhood Health Center Staff to report any abuse of vulnerable individuals, which includes children, elders, persons who are mentally ill, developmentally disabled, or living in a long term care facility to The Department of Human Services that is witnessed or learned of inside or outside of a Neighborhood Health Center Clinic.
- I understand I may choose not to talk about sensitive information, such as the age(s) of sex partner(s), and that I will still get services.

I understand that if I get reproductive health services here, I can still apply for or get services from other programs. If I get care from other programs, I can still get services at Neighborhood Health Center.

DENTAL SERVICES

I understand that Neighborhood Health Center partners with different academic institutions and that I may be treated by a student/extern practicing under the direct supervision of a licensed professional at Neighborhood Health Center. I authorize Neighborhood Health Center professionals and their partners to provide such treatment and this authorization shall remain in effect until revoked in writing.

Patient Signature	***Date***
Signature of Patient's Representative *(If patient is under 18)*	***Date***
Relationship of Representative	

COMMUNICATION PERMISSIONS FOR PROTECTED HEALTH INFORMATION (PHI)

Patients who are minors (under age 18) may request certain levels of confidentiality and consent to various health care matters depending on their age. Further details regarding this can be provided by NHC staff.

Patient Name:	**Date of Birth:**

IT IS OK FOR NEIGHBORHOOD HEALTH CENTER TO CONTACT YOU? *(please check all that apply)*:

1. Can we send bills to your address? ❑ Yes ❑ No
2. Can we send automated appointment reminders? ❑ Yes ❑ No
   If yes, which type? ❑ Phone call ❑ Text message
3. Can we call you regarding your visit/treatment with us? Types of calls that could be made:
   - Primary Care (lab Results, medical instructions, referrals, medications, etc.) ❑ Yes ❑ No
   - Dental Care ❑ Yes ❑ No
   - Behavioral Health (follow up on concerns, referrals, etc) ❑ Yes ❑ No
   - Reproductive Health (sexual health, STI treatment, test results) ❑ Yes ❑ No

Preferred Communication: ❑ Do not contact ❑ Mail ❑ Phone ❑email via MyChart ❑ No preference

If the answer to any of the above is No, how may we reach you regarding your critical healthcare?

Name of contact:

Phone number:

If you sign up for MyChart, all your information is available online. Ask the receptionist to help you sign up for MyChart

WHO MAY WE SPEAK TO REGARDING YOUR HEALTHCARE? & EMERGENCY CONTACTS *(NOTE: this is not an authorization to release records):*

I authorize Neighborhood Health Center to speak to the following people, in person or by telephone: ❑ Not Applicable

Name: _____

Relationship: _____ **Phone:** _____

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*:
❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other:

Name: _____

Relationship: _____ **Phone:** _____

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*:
❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other:

Name: _____

Relationship: _____ **Phone:** _____

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*:
❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other: _____

PLEASE LIST LEGAL REPRESENTATIVE, GUARDIAN, POWER OF ATTORNEY, ETC. IF ANY *(please provide proof)*

Name: _____ ❑ Not Applicable

Relationship: _____ **Phone:** _____

Name: _____

Relationship: _____ **Phone:** _____

SIGNATURE REQUIRED *(below):*

The authorization may be changed or revoked in writing at any time. It will remain in effect until one (1) year from the date below. By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

Signature (Patient/Legal Guardian)	***Date***
Print Name	***Relationship***

INCOME VERIFICATION FORM

Patients who would like to apply for the sliding fee discount must declare their interest at the time of their visit. They must also fill out an income verification form and provide proof of gross income (income before taxes) as described below. Patients in our Title X program are exempt from this requirement.

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify Neighborhood Health Center Clinic of that change.

(*) Patients are required to give at least one of the following items as verification of income:

1. Previous year completed tax return
2. Previous year W-2
3. 2 most recent pay stubs
4. Letter from employer
5. Check stubs from Unemployment Insurance
6. Previous 3 months bank statements
7. Self-employed individuals must provide their prior year tax return and most recent 3 months of income

Patient Name: _____ **Date of Birth:**_____

Eligibility for the sliding fee scale is based on total household income. Please list all family members within this household and combine their monthly income for the sliding scale discount.

Family Member : _____ Date of Birth:_____

Family Member :_____Date of Birth:_____

Family Member :_____Date of Birth:_____

Family Member :_____Date of Birth:_____

Family Member :_____Date of Birth:_____

Number of Family Members: _____ Combined Monthly Payroll Amount $ _____

Payroll Frequency: _____ Weekly_____ Bi-Weekly _____ Semi-Monthly _____ Monthly

Signature of Patient or Personal Representative: _____**Date:** _____

2018 FEDERAL POVERTY GUIDELINES	
Family Size	**Monthly Income 200% or Less**
1	$2,023.00
2	$2,743.00
3	$3,463.00
4	$4,183.00
5	$4,903.00
6	$5,623.00
7	$6,343.00
8	$7,063.00

OFFICE USE ONLY

Household Monthly Income According to Documentation $ _____

Documentation Type: _____

Reviewed By: _____

Date _____

Family units more than 8 members, add $720.00 for each additional member

AUTHORIZATION FOR NHC TO RECEIVE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____
Previous Name: _____

I request & authorize the Individual / Clinic / Provider listed below to release a copy of my medical record to NHC:

Name of Individual / Clinic / Provider: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone: _____ **Fax:** _____

This authorization gives permission to release the following records:

- Problem list
- Medication list
- Last three progress notes
- Specialty provider consult notes
- All labs, EKG's, and diagnostic studies from previous year
- All pap smear results
- All colonoscopy results
- Immunization record
- Other: _____

I understand that certain information cannot be released without specific permission as required by State / Federal law. By initialing, I authorize the release of the following protected or sensitive information.

(please initial)		(please initial)	
_____	Drug / Alcohol Diagnosis, Treatment, and/or Referral Information	_____	STD / AIDS / HIV Testing
_____	Mental Health Diagnosis and/or Treatment	_____	Genetic Testing

_____

Patient / Guardian Signature ***Relationship to Patient*** ***Date***

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon this authorization. A revocation will not affect inspection of records necessary to validate expenditures by or on behalf of government entities. To revoke this authorization, please send a written statement to Neighborhood Health Center and state that you are revoking this authorization. Unless revoked earlier, this consent will expire upon the event or date indicated: _____ or after one year from the date signed if left blank.

TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION: The information disclosed to you by this authorization is protected by state law (ORS 179.505, 192.516) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.

INSTRUCTIONS FOR COMPLETING THIS FORM

Section 1: Complete each box as indicated with the following information:

- Patients Name (Print Clearly)
- Other names patient has used. If none, leave blank
- Date of Birth

Section 2: Write the name or company that is to receive/release the information. Include as much as information as you can:

- Name or Company
- Address (including city, state and zip code)
- Phone number
- Fax number

Section 3: Initial for any sensitive information protected by law you want to be released.

Please sign your name, authorizing the information on the release is correct and approved by you. If you are not the patient, describe your relationship and legal authority to sign. You will be required to provide the legal paperwork. Date the authorization.

ADULT HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

What is the reason for visit? _____

List any allergies (medication, environmental, food, etc.)	**Reaction**

List any medications you are taking (Including vitamins, herbs, diet pills, over the counter, and prescription)	**Dosage**	**Frequency**

What pharmacy do you use? _____

PERSONAL MEDICAL HISTORY

Allergies	❑Yes ❑No	Emphysema/COPD	❑Yes ❑No	Liver disease	❑Yes ❑No
Anemia	❑Yes ❑No	Heart failure	❑Yes ❑No	Nerve/muscle disease	❑Yes ❑No
Anxiety	❑Yes ❑No	Heart murmur	❑Yes ❑No	Osteoporosis	❑Yes ❑No
Arthritis/Joint Disorder	❑Yes ❑No	HIV/AIDS	❑Yes ❑No	Seizures	❑Yes ❑No
Asthma	❑Yes ❑No	High Cholesterol	❑Yes ❑No	Stomach Ulcers	❑Yes ❑No
Cancer	❑Yes ❑No	High Blood Pressure	❑Yes ❑No	Stroke	❑Yes ❑No
What kind? _____		Heart attack	❑Yes ❑No	Thyroid disease	❑Yes ❑No
Diabetes	❑Yes ❑No	Kidney disease	❑Yes ❑No	Substance abuse	❑Yes ❑No
Depression	❑Yes ❑No				

List any other health conditions: _____

WOMEN'S HEALTH HISTORY

Last Pap smear?_____ Were the results normal? ❑Yes ❑No History of abnormal pap smears? ❑Yes ❑No

Are you having regular periods? ❑Yes ❑No When was the first day of your last menstrual period? _____

Have you ever been pregnant? ❑Yes ❑No How many times have you been pregnant? _____

When was you last mammogram? _____

SURGICAL HISTORY

Appendectomy	❑Yes ❑No	C-Section	❑Yes ❑No	Joint replacement	❑Yes ❑No
Brain surgery	❑Yes ❑No	Eye surgery	❑Yes ❑No	Spine surgery	❑Yes ❑No
Gallbladder surgery	❑Yes ❑No	Fracture surgery	❑Yes ❑No	Tubal ligation	❑Yes ❑No
Colon surgery	❑Yes ❑No	Heart surgery	❑Yes ❑No	Vasectomy	❑Yes ❑No
Cosmetic surgery	❑Yes ❑No	Hernia repair	❑Yes ❑No	Tonsillectomy	❑Yes ❑No
What kind? _____		Hysterectomy	❑Yes ❑No		

List any other surgeries you have had: _____

(PLEASE COMPLETE REVERSE SIDE)

FAMILY HISTORY

Relationship	Alive?	Age	Alcohol / Drug Addiction	Cancer	Heart Problems	Diabetes	High Cholesterol	High Blood Pressure	Mental Health
Mother									
Father									
Sister									
Brother									
Daughter									
Son									

❑ Family history unknown ❑ Adopted If cancer selected, what type of cancer? _____
Other family history: _____

SOCIAL HISTORY

Tobacco Use Currently using? ❑ Yes ❑ No Former use? ❑ Yes ❑ No Ready to quit? ❑ Yes ❑ No

Type of tobacco used: ❑ Cigarettes ❑ Pipe ❑Cigars ❑E-cig ❑Snuff ❑Chew

How much of a pack do you currently or have you previously smoked per day? _____

How many years have you or did you smoke for? _____ What year did you quit? _____

Drug Use Currently using? ❑ Yes ❑ No Former use? ❑ Yes ❑ No

❑Marijuana ❑Cocaine ❑Ecstasy ❑IV ❑Heroin ❑LSD ❑Crack ❑Methamphetamine ❑Other: _____

How do you use? ❑ Smoke ❑ Inject ❑ Other: _____ How many times per week? _____

Alcohol Use ❑ Yes ❑ No

Number of drinks per week ____ Glasses of wine (5oz) ____ Cans of beer (12oz) ____ Shots of liquor (1.5oz)

Sexually Active ❑ Yes ❑ No Partners: ❑ Men ❑ Women ❑ Both

Birth control: ❑Condom ❑Birth Control Pill/Patch ❑Implant ❑Injection ❑IUD ❑Surgical ❑Menopause ❑Other: ____

How many children do you have? _____

Lifestyle

Do you exercise? ❑ Yes ❑ No How many days per week? _____ For how long (hours or minutes)? _____

Do you follow any specific diet? ❑ Yes ❑ No If yes, what kind? _____

Home Environment

Do you have a steady place to live? ❑Yes ❑Yes, but I am worried about losing it ❑No (temporary, homeless, shelter, other)

How often do you feel lonely? ❑Never ❑Rarely ❑Sometimes ❑Often ❑Always ❑Decline to answer

How much stress have you experienced in the last month? ❑None ❑A little bit ❑Somewhat ❑Quite a bit ❑Very much ❑Decline to answer

Do you have someone you can call for help? ❑ Yes ❑ No

Relationship Safety Because violence & abuse happens to a lot of people & it affects their health, we are asking the following:

How often does anyone, including family and friends:

Physically hurt you? ❑Never ❑Rarely ❑Sometimes ❑Fairly Often ❑Frequently

Insult or talk down to you? ❑Never ❑Rarely ❑Sometimes ❑Fairly Often ❑Frequently

Threaten or harm you? ❑Never ❑Rarely ❑Sometimes ❑Fairly Often ❑Frequently

Scream or curse at you? ❑Never ❑Rarely ❑Sometimes ❑Fairly Often ❑Frequently

SBIRT

Patient Name: _____ Date: _____

Once a year, all our patients are asked to complete this form because drug use, alcohol use, and mood can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:	 12 oz. beer	 5 oz. wine	 1.5 oz. liquor (one shot)

	No	Yes
Are you currently recovering from alcohol or substance abuse?	❑	❑

ALCOHOL	None	One or more times
For men: How many times in the past year have you had **5 or more** drinks in a day?	❑	❑
For women: How many times in the past year have you had **4 or more** drinks in a day?	❑	❑

DRUGS	None	One or more times
How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?	❑	❑

MOOD Over the last **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half of the days	Nearly every day
Little interest or pleasure in doing things	❑	❑	❑	❑
Feeling down, depressed, or hopeless	❑	❑	❑	❑

PHQ-9

PATIENT NAME: _____ DATE: _____

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding your health.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all **0**	Several days **1**	More than half the days **2**	Nearly Every day **3**
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself — or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
Trouble concentrating on things such as reading the newspaper or watching TV	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
TOTAL				

If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

Severity Scale:	5-9 minimum	10-14 minor	15-19 moderate	> 20 severe