Patient Information and Registration Form

First Name: ______________________ MI: ____ Last Name: ______________________ Date of Birth: __________

Preferred Name: ____

Address: ____

City: ______________________ State: ______________ Zip Code: __________

Contact Information

Home Phone: ______________________

Cell Phone: ______________________

Email Address: ______________________

Please circle one:

Which is the better phone to reach you? Home/Cell

Can we leave a voicemail: Yes/No

Can we email you: Yes/No

Demographic Information

Sexual Orientation and Gender Identity:

What sex were you assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Other/Intersex

What are your preferred pronouns?

- ☐ He/Him
- ☐ She/Her
- ☐ They/Them/Us
- ☐ Other *(please specify)*: ______________

What is your current Gender Identity?

- ☐ Male
- ☐ Female
- ☐ Female-to-Male (FTM)/ Transgender Male
- ☐ Male-to-Female (MTF)/ Transgender Female
- ☐ Genderqueer (neither male nor female)
- ☐ Do not want to disclose

What is your sexual orientation?

- ☐ Straight/Heterosexual
- ☐ Do not know
- ☐ Lesbian/Gay/Homosexual
- ☐ Do not want to disclose
- ☐ Bisexual
- ☐ Something else *(please describe)*: ______________

Are you a veteran? Yes/No

Race, Ethnicity, and Language

Please circle your race:

- ☐ Asian
- ☐ White/Caucasian
- ☐ Native Hawaiian
- ☐ More than one race
- ☐ Other Pacific Islander
- ☐ Unknown
- ☐ Black/African American
- ☐ Do not want to disclose
- ☐ American Indian/Alaska Native

Please select the Ethnicity:

- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Do not want to disclose

Preferred language other than English:

- ☐ Amharic
- ☐ Pashto
- ☐ Chinese
- ☐ Persian
- ☐ French
- ☐ Spanish
- ☐ Other *(please specify)*: ______________

Relationships and Financial Information:

What is current marital status:

- ☐ Single
- ☐ Domestic Partnership
- ☐ Widowed
- ☐ Unknown
- ☐ Married
- ☐ Divorced
- ☐ Legally Separated

Family size: ______________________

Current earnings: ______________________

Weekly/Bi-Weekly/Monthly/Annually *(please circle one)*

Privacy

Name: ______________________________

I understand that a patient's health information is private and confidential. I understand that CCI Health Services (CCI) works very hard to protect a patient's privacy and preserve the confidentiality of a patient's personal health information. I understand that CCI may use and disclose a patient's personal health information to help provide health care to a patient, to handle billing and payment, and to take care of other health care operations. CCI has a detailed document called the Notice of Privacy Practices. It contains more information about the policies and practices protecting a patient's privacy. I understand that I have the right to read the Notice before signing this agreement.

- CCI may update this "Notice of Privacy Practices". If asked, CCI will provide me with the most current Notice of Privacy Practices.
- Under the terms of this consent, I can ask CCI to limit how the patient's personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that CCI does not have to agree to my request. If CCI does agree to my request, I understand that CCI would follow the agreed limits.
- I may cancel this consent in writing at any time by writing, signing, and dating a letter to CCI Privacy Officer at **Support Center, 8665 Georgia Avenue, Silver Spring, Maryland 20910**. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.
- If I revoke this consent, CCI does not have to provide any further health care services to the patient.
- My signature below indicates that I have been given the chance to review and/or received a current copy of CCI's Notice of Privacy Practices.
- My signature means that I agree to allow CCI to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

Please print clearly and sign below.

Patient or legally authorized individual's signature: ______________________ Date: __________

Signed by (*circle one*): Patient/Parent/Legal Guardian/Caregiver

Emergency Contact

Name: ____________________ Relationship: ____________________

Phone Number: ____________________ Email: ____________________

Optional

I authorize the following person(s) to receive my personal health care information.

Name: ____________________ Relationship: ____________________

Name: ____________________ Relationship: ____________________

Date: __________

How did you learn about CCI?

☐ Google ☐ Family ☐ PCC ☐ Social Media

☐ Friend ☐ Dept. of Health ☐ Insurer ☐ Provider

☐ Other: ______________________________

For Office Use Only. If any of the above is marked NO, marked patient confidential in alert note.

For Adolescent Services/ Family Planning Patients

Please print password here: ______________________________

Include password in confidential alert note.

Informed Consent for In-Person or Telehealth Treatment

Please read this document carefully and print all information in the spaces provided.

First Name: ______________________ MI: ____ Last Name: ______________________ Date of Birth: __________

Treatment

1 | I am voluntarily seeking diagnostic services and treatment from CCI Health Services. I understand that as part of my medical care, I may be tested for drug use and sexually transmitted diseases including, but not limited to, the human immunodeficiency virus (HIV).

2 | I have received information and advice from my health care provider as to my condition and the diagnostic services, procedures, and/or treatment that are considered necessary and appropriate for me. My health care provider has explained to me the nature of the diagnostic services, procedures, and/or treatment that I am to receive and the reasonably foreseeable risks, benefits, and reasonable alternatives.

3 | I have had the opportunity to ask my health care provider questions prior to the performance of the services, procedures, and/ or treatment and am aware of my right to refuse the service, procedure, and/or treatment.

4 | I understand that the explanation that was given to me by my health care provider as to the nature, intended purpose, and the reasonably foreseeable risks, consequences, complications, and benefits of the diagnostic services, procedures, and/ or treatment(s) to be performed or used in the course of diagnosing and/or treating my condition and the alternatives, is not exhaustive and that other risks and complications may arise. I also understand that the practice of medicine is not an exact science and that it is not reasonable to expect my health care provider to be able to anticipate or explain all of the potential risks and complications.

5 | I have received no assurances with respect to any benefits hoped to be realized or outcomes or consequences that may results from any of the diagnostic services, procedures, and/or treatment(s) to be performed.

6 | I understand that I can obtain a copy of this signed consent form, upon my request. I have been given the opportunity to request a sign language interpreter or foreign language interpreter in the event that I am hearing impaired or incapable of understanding what is being said in English.

7 | I consent to CCI Health Services' retention and disposal of any blood, urine, and other bodily fluids or specimens that it obtains in the course of my evaluation and treatment.

8 | I understand that this Consent to Treatment means that I can voluntarily receive medical, dental, behavioral health and care management services from CCI Health Services. I also understand that I can revoke my consent for any or all of these services at any time by informing CCI Health Services in writing.

By signing below I acknowledge that I have read this document in its entirety and consent to have CCI Health Services' health care provider's perform those diagnostic services, procedures, and/or treatments considered to be necessary and appropriate for my evaluation and treatment.

Patient or legally authorized individual's signature: ______________________ Date: __________

Signed by (*circle one*): Patient/Parent/Legal Guardian/Caregiver

Telehealth

1 | I agree to participate in a telehealth appointment. I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to a patient when he/she is located at a different site than the provider and I hereby consent to CCI Health Services providing health care services to me via telehealth.

2 | I understand that the medical provider may determine that telehealth is not clinically appropriate and request that I come for an in person appointment.

3 | I understand that the laws that protect privacy and confidentiality of medical information apply to telemedicine. There is a small risk that this technology could result in a breach of privacy. CCI has taken all required steps to protect confidentiality and to abide by all state and federal privacy laws. In the eyent that there would be any breach of confidentiality CCI has a data breach policy and will inform me in a timely manner of any breaches and all steps taken to remediate the problem.

4 | I understand that CCI staff are bound by confidentiality and are here to assist me but that I have the right to exclude anyone during the telehealth session.

5 | I understand that I have the right to withhold or withdraw my consent to use telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke by consent orally or in writing by informing the practice manager. As long as this consent is in force or has not been revoked the provider may provide health care services to me via telehealth without the need to sign another consent form.

Patient or legally authorized individual's signature: ______________________

Signed by (*circle one*): Patient/Parent/Legal Guardian/Caregiver Date: __________

Witness: ______________________ Date: __________

Permission to Treat Minor Patient (less than 18 years of age) Without Parent/Legal Guardian Present

CCI Health Services must receive permission from a child's parent or legal guardian prior to providing treatment(s) for medical care, dental care, injury or illness that is non-life threatening, with the three exceptions noted at the bottom of this page. A parent/legal guardian/kinship caregiver MUST be present for a minor patient's first visit with CCI Health Services (with the 3 exceptions noted at the bottom of this page) and for well-child medical visits. For other visits, this form provides the legal permission to treat the minor with a designated adult (non-parent/guardian) present. It is expected that the designated adult is aware of the minor's medical history, including medications and allergies.

Please print all information in the spaces provided. Be sure to complete all fields and sign below.

Patient Name: ______________________ Date of Birth: __________ Today's Date: __________

Delegation of authority for medical treatment of a minor child to the designated representative indicated below:

I, (*print your name*) ______________________ grant CCI Health Services permission to assess and treat the aforementioned minor in the presence of any of the following adults who are authorized to approve treatment:

Last name:	First name:	Relationship to minor:
Last name:	First name:	Relationship to minor:
Last name:	First name:	Relationship to minor:

By signing, I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered. Please Note: Insurance card(s) and co-pay amounts (if applicable) must be presented at each visit.

Patient or legally authorized individual's signature: ______________________ Date: __________

Signed by (*circle one*): Patient/Parent/Legal Guardian/Caregiver

This authorization is valid:

☐ For one visit only (*date of appointment*): ______________ ☐ For one year from the date the authorization is signed

Parent/Guardian Emergency Contact Phone #1: ______________________

Parent/Guardian Emergency Contact Phone #2: ______________________

NOTE: Articles 20-102 and 20-104 of the Annotated Code of Maryland (State Law) allow for the following exceptions, where a minor has the same capacity as an adult to consent to medical treatment:

1 | Treatment for and/or advice about drug abuse and/or alcohol abuse, including psychological treatment.

2 | Treatment for and/or advice about venereal (sexually transmitted) disease (including HIV/AIDS), pregnancy, or contraception other than sterilization.

3 | I Consultation, diagnosis and treatment of a mental or emotional disorder (if 16 years of age or older).

Appointment No-Show Agreement

Please read this document carefully and print all information in the spaces provided.

Name: ____ Date of Birth: __________________

It is a policy of CCI Health Services to monitor and manage appointment no-shows. This is necessary to ensure that each patient is given the proper amount of time allocated for their visit and to provide the highest quality care. Undue numbers of unutilized appointments delay necessary medical care for patients. A "no-show" is when someone misses an appointment without canceling it within a 24-hour working-day period in advance.

Patients must cancel their scheduled appointment with at least a 24-hours' notice. If less than a 24-hour cancellation is given, this will be documented as a "no-show" appointment. Patients who fail to arrive for a scheduled appointment will be documented as a "no-show" appointment.

If a patient has three "no-shows" appointments in a row within six months, that patient and any person who is either a guarantor for, or guarantee of the patient, will not be able to schedule future appointments in advance. Front office staff may exercise limited discretion in not assigning "no shows" to accounts for special circumstances, such as hospitalization or other emergency.

By signing below I acknowledge that I have read and understand the CCI Health Services Appointment No-Show Policy and agree to its terms.

Patient or legally authorized individual's signature: ________________________ Date: ______________

Signed by (*circle one*): Patient/Parent/Legal Guardian/Caregiver

Sliding Fee Scale (SFS) Discount Application

First Name: ________________________ Date of Birth: ____________

The Sliding Fee Discount Program is available to low-income, uninsured patients, and/or underinsured patients of CCI. The program assists patients in reducing the amount a patient pays for preventative primary health care services at CCI Health Services. No patient is denied services due to the inability to pay. All patients who it has been determined are at or below 100% of the Federal Poverty Guidelines will be charged a nominal fee. The nominal fee is a flat fee not associated with the cost of the service provided.

In order to be eligible for the Sliding Fee Scale (SFS) Discount Program, you must provide a proof of income within 30 days of your appointment. If you're applying for the SFS Discount Program, please provide one of the following forms of proof of income, family size, and current earnings:

What is not covered?

Medical

- Medications/prescriptions
- Out of scope services

Dental

- Medications/prescriptions
- Out of scope services
- Outside laboratory fees
- Supplies

Proof of Income & Family Size:

The Sliding Fee Discount Program requires family size, current earnings, and two pieces of information in order to establish eligibility, which may include:

- Pay stubs totaling one month of income payment(s)
- Current Federal Tax Return
- Letter from Employer (with income verified in letter, contact person, and phone number)
- Employment Offer Letter with annual income confirmation (with contact person and phone number)
- Documents verifying amount of additional income sources (*Select all that apply. Must have documentation.*)

☐ Aid to Dependent Children (ADC)
☐ Alimony
☐ Child Support
☐ Disability
☐ Pension
☐ Retirement
☐ Social Security Income
☐ Unemployment
☐ Welfare Assistance

Family Size: A family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. **Please define your family size and income.**

Family Size: ________________________

Current earnings: ________________________
Weekly/Bi-Weekly/Monthly/Annually (*please circle one*)

Domestic Partner/Spouse earnings: ________________________
Weekly/Bi-Weekly/Monthly/Annually (*please circle one*)

Additional Family Member earnings: ________________________
Weekly/Bi-Weekly/Monthly/Annually (*please circle one*)

Additional Family Member earnings: ________________________
Weekly/Bi-Weekly/Monthly/Annually (*please circle one*)

Today I did not have the following documents ready when applying for my Sliding Fee Discount, and I understand that in order to get my Sliding Fee Discount, I will need to bring in this document by **this date:** ____________ . This sliding fee discount program application will be effective for one year from the date of application.

Patient or legally authorized individual's signature: ________________________ Date: ____________

Signed by (*circle one*): Patient/Parent/Legal Guardian/Caregiver

Denial of Sliding Fee Discount Program

☐ I have elected to opt-out of the Sliding Fee Discount Program and understand that the fees will not be discounted. I certify that the above information is true and correct to the best of my knowledge and that I have read and understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.

Staff Only

Name: ________________________ Title: ________________________

Signature: ________________________ Date: ____________