



# Welcome to your Health Care Home!

Thank you for choosing our Community Health Center as your Health Care Home. As your Health Care Home, you will be asked to select a primary provider, who will oversee all of the care you receive. That provider is assisted by a care team made up of nurses and other support staff. Your care team will coordinate your health care throughout all settings inside and outside of our Community Health Center to promote better health for you, our patient.

We provide the highest quality of health care, based upon current medical, dental, and behavioral health research, standards, and protocols. We provide integrated care so that all of your providers work together to provide comprehensive and holistic care that considers every aspect of your health. We will involve you in the decisions made on your behalf.

As a Health Care Home, we function best when we have your complete medical history and information about health care obtained by other providers outside of this Health Center. We will always ask you for updates about other medical, dental, and mental health care you have received, so we can stay up to date and provide the most appropriate and continuous service possible.

Also as a Health Care Home, we provide timely clinical advice on the telephone and via a secure web-based Patient Portal, both during office hours and when the office is closed. Instructions for obtaining care and clinical advice using the telephone and Internet are included in this welcome packet.

At our Center, no one is denied service due to an inability to pay. Persons with limited income may qualify for our Discount Fee Program. Please inquire.

## Montgomery Center

215 Roanoke Street, Christiansburg, VA 24073

Ph: 540-381-0820

Hours: 8:00—5:00 Monday-Friday  
Also 5:00—7:00 pm Thursday evenings

## Giles Center

219 Buchanan Street, Pearisburg, VA 24134

Ph: 540-921-3502

Hours: 8:00—4:30 Monday-Friday

## Pulaski/Radford Center

5826 Ruebush Road, Dublin, VA 24084

Ph: 540-585-1310

Hours: 8:30—5:00 Monday-Friday

## After-Hours Call Service for All Sites:

804-729-5122

## We provide the following services to people of all ages:

- Primary Health Care
- Check-ups, Preventive Care
- Chronic Disease Management
- Care Coordination and Referrals
- Well Child Visits, Vaccinations
- Behavioral Health Services
- Medication Assistance
- General Dentistry, including extractions, cleaning, fillings, crowns, bridges, and dentures
- Insurance Assistance, with the Federal Health Insurance Marketplace, Medicare, Medicaid, and FAMIS

*A Language Line is available for patients who need translators.*

# Community Health Center of the New River Valley

## Patient Registration Form

**First Name:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State & Zip Code:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Parent/Legal Guardian:** \_\_\_\_\_

**Preferred Method of Contact (circle):**

Home Phone    Cell Phone    Text Message    Email

**Occupation:** \_\_\_\_\_

**Sex:**    Male    Female    Other

**Sexual Orientation (circle):**

Straight (not lesbian or gay)    Lesbian/Gay    Bisexual  
 Something Else    Don't Know    Choose not to disclose

**Gender Identity (circle):**    Male    Female

Transgender Male/Female-to-Male    Other

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

**How did you hear about us:** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_

**Are you a (circle one):**

U.S. Citizen    U.S. Resident    Other

**Are you a United States Veteran?**    Yes    No

**What is your primary language?** \_\_\_\_\_

**Do you require an interpreter?**    Yes    No

**Race (select all that apply):**

\_\_\_ African-American    \_\_\_ Native American

\_\_\_ Asian    \_\_\_ Pacific Islander

\_\_\_ White    \_\_\_ Hispanic

\_\_\_ Other

**Ethnicity (select one):**

\_\_\_ Hispanic    \_\_\_ Non-Hispanic

**Phone Contact Permission:**

List person/persons whom the Center (CHCNRV) may contact in the event we are not able to speak to you or in the event of an emergency.

**Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

### Primary Insurance Company Information

**Company:** \_\_\_\_\_

**Subscriber/Policy/Medicare/Medicaid Number:**

**Group Number:** \_\_\_\_\_

### Primary Policy Holder Information

**Policy Holder Name:** \_\_\_\_\_

**Policy Holder DOB:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Policy Holder Address:** \_\_\_\_\_

### No Insurance Coverage:

I currently do not have any medical insurance or pharmacy prescription coverage, whether through the government (Medicare or Medicaid), employment, or a private company. When I receive insurance coverage or pharmacy prescription coverage, I will notify the Community Health Center within 30 days of the start date of the new insurance and will provide a copy of my card.

**Initial here:** \_\_\_\_\_

**By signing below, I am acknowledging that the above information is true and accurate to the best of my knowledge. I have had the opportunity to review the Notice of Privacy Practices and the No-Show Policy. I also attest that if it is found that I am knowingly withholding insurance information and the time frame to file previous claims has been exceeded, I will be held responsible for any past due amounts.**

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



# Community Health Center of the New River Valley

## Health History Form

### SHOTS

When was your last **Tetanus shot**? Year \_\_\_\_\_  never  don't know  
When was your last **Pneumonia shot**? Year \_\_\_\_\_  never  don't know  
When was your last **Flu shot**? Year \_\_\_\_\_  never  don't know

### SOCIAL HISTORY

**Do you smoke cigarettes, cigars, use snuff, chew tobacco, or vape?**

No (if no, go to next question)  
 Yes, When did you start? \_\_\_\_\_ How much per week? \_\_\_\_\_

**Do you drink alcohol?**

No (if no, go to next question)  
 Yes - How many drinks do you typically drink in a week? \_\_\_\_\_ drinks

**Do you use anything to help you walk?**  Yes  No If yes, what? \_\_\_\_\_

**Check any of the following types of help at home you receive (paid help or family and friends).**

Cleaning/laundry  Shopping  Personal Care  Taking medications  None

**In the past year, do you feel that you have been emotionally or physically abused?**  Yes  No

### HISTORY OF MEDICAL CONDITIONS

Have you **ever** had any of the following conditions? (Check all that apply)

Anemia (low iron blood)  Asthma (wheezing)  Diabetes (sugar)  
 Heart Trouble  Hemorrhoids (piles)  Cancer  
 Hepatitis (yellow jaundice)  Tuberculosis (TB)  Pneumonia  
 Rheumatic fever  Ulcers  Stroke  
 High Blood Pressure  Skin problems  Depression (feeling down or blue)  
 Epilepsy (fits, seizures)  Anxiety (nerves, panic attacks)  
 STD (gonorrhea, HIV)  Other \_\_\_\_\_

### FOR WOMEN ONLY

Have you ever been or currently pregnant?  Yes - How many times? \_\_\_\_\_  No  
How many children have you given birth to? \_\_\_\_\_

Do you use birth control? (the pill, condoms, intra-uterine device, Nexplanon)  Yes  No  
If yes, which kind? \_\_\_\_\_

Have you had a PAP smear?  Yes  No  
Date of last one \_\_\_\_\_ Where: \_\_\_\_\_

Have you ever had a PAP smear that was not normal?  Yes  No

Have you had a mammogram (breast x-ray)?  Yes  No  
Date of last one \_\_\_\_\_ Where: \_\_\_\_\_

### RELEASE OF INFORMATION

# Community Health Center of the New River Valley

## Health History Form

List any person who we can talk to about your medical conditions (Protected Health Information) and your appointments. This *excludes Behavioral Health and Substance Abuse conditions (Sensitive Protected Health Information)*, a separate release of information will need to be signed to discuss these with other individuals.

Name	Phone Number	Relationship

**By signing below, I agree that I have provided true answers to the best of my knowledge. It is my responsibility, as the patient, to contact previous physician's offices for transfer of medical records. I have the ability to ask for a copy of my medical records at any time from CHCNRV. I have reviewed the Notice of Privacy Practices (HIPAA).**

Signature of Patient or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# Community Health Center of the New River Valley

---

## Dental Health History

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex (circle one): Male or Female

When was your last dental visit? \_\_\_\_\_

What was the reason for your last visit?

---

Do you brush daily? YES or NO times per day: \_\_\_\_\_

Do you floss daily? YES or NO times per day: \_\_\_\_\_

Do you have a specific dental problem or concern?

---

---

---

How would you rate your current dental health?  Good  Fair  Poor

Are you currently in discomfort? YES or NO

Have you been to the ER in the last year for dental issues? YES or NO

If yes, when and where did you go?

---

Have you gone to the ER several times for the same problem? YES or NO

If yes, how many times? \_\_\_\_\_

Do you have Osteoporosis? YES or NO

Do you have a history of taking Bisphosphonates? (Bisphosphonates are prescription drugs that are commonly used to treat Osteoporosis, like Boniva or Fosamax) YES or NO

Do you require antibiotic pre-medication prior to dental work? YES or NO

Do you have tooth sensitivity to:

heat  cold  sweet  discomfort when biting

recurring sores or blisters in/on your mouth, tongue, lips, etc.

# Community Health Center of the New River Valley

---

## Acknowledgments and Authorizations Form

**Patient Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**Sign your initials next to each section:**

\_\_\_\_\_ **CONSENT FOR TREATMENT:** I authorize the employees, agents and staff of the Community Health Center to perform and hereby consent to such medical treatment and examinations, including diagnostic procedures or behavioral health evaluations, as may in the opinion of the patient's physician be necessary.

\_\_\_\_\_ **NO GUARANTEE:** I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments or examinations.

\_\_\_\_\_ **RELEASE OF INFORMATION:** I authorize the center to release any and all patient medical and billing information to any physician involved in my treatment; to any healthcare facility to which I/the patient is discharged or transferred to for treatment, billing, quality assurance, collection, or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by the Community Health Center. I consent to the use and/or disclosure of my protected health information to carry out treatment, payment or healthcare operations by the Community Health Center.

\_\_\_\_\_ **DEEMED CONSENT FOR BLOOD TESTING:** I understand that under Virginia Law, if a healthcare provider, a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to body fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consent for testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) A patient who tests positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

\_\_\_\_\_ **BILLING INFORMATION:** It is important that you provide us with complete and accurate information (i.e. home address, phone numbers) so that we may properly submit billing data to your insurance company. We will make every effort to submit claims to your insurance company and promptly provide you with our statements. However, if for any reason the statement is returned to our office because of a problem with an address you provided, we will call you to secure full payment. Please ensure that all of your information is accurate and up-to-date. **Please be sure to bring your photo identification and your insurance cards to every visit** so that we may properly bill your insurance company. If you do not have your insurance card with you, you may be required to make payment in full that day.

\_\_\_\_\_ **FINANCIAL RESPONSIBILITY/MEDICARE/MEDICAID:** I understand that I am financially responsible for all charges, whether or not paid by insurance. The Community Health Center does not participate in **EVERY** insurance plan. I understand that I am responsible for verifying that the Community Health Center provider is a participating provider in my insurance plan. Patients' are responsible for understanding benefits. Payment is expected at the time of service. I understand that I/the patient am responsible for any deductibles, co-payments and any applicable percentage of remaining charges.

\_\_\_\_\_ **DISCOUNT FEE PROGRAM:** Qualifying for our discount fee program based on your family income and family size may result in lower charges. You are required to report any income and family size changes to us as this may impact the amount you are expected to pay. We will review and update your information annually. Eligibility cannot be determined until we receive all requested information. **If it is determined you are not eligible for the discount fee program and you have incurred charges, you will be expected to pay the balance due.** We will assist you by arranging a payment plan if needed.

\_\_\_\_\_ **CERTIFICATION AND ACKNOWLEDGEMENT:** I certify that all of the above information and all information supplied by me, as part of the registration process, is correct. I also acknowledge receipt of the Community Health Center's Notice of Privacy Practices (HIPAA).

\_\_\_\_\_  
Patient or Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Signature

# Community Health Center of the New River Valley

---

## Application for Discount Fee Program

Welcome to the Community Health Center of the New River Valley. We offer affordable health care and dental care through the use of a Discount Fee Program to all patients at or below 200% of the poverty level. All patients are eligible to apply for the discount fee program.

If you want to apply for the discount fee program, you must meet with a Patient Services Representative (PSR) who will review your patient packet and discount fee program application. At this time, the PSR can answer any questions you may have regarding the Discount Fee Program and how it works.

*If you are applying for the discount fee program, please complete the attached Household Financial Information Form.*

**You are required to bring proof of identification and ALL income that is received in your household.**

### **Examples of Income:**

- Paycheck stubs for most recent full month of work
- Bank Statement showing income deposits
- Social Security Letter
- SNAP/WIC Benefits Letter
- Self -Employment Documentation (Taxes are Recommended)
- Letter from Employer
- Retirement/Pension
- If you have no income, we ask for a Letter of Support signed by the person who provides you with basic necessities
- Documentation of income from any other source

### **Our Patient Services Representatives are available:**

Montgomery Center: Monday, Tuesday, and Thursday, from 8:30am to 4:30pm.

Pulaski/Radford Center: Monday – Friday, from 8:30am to 4:30pm.

Giles Center: Monday – Friday, from 8:00am to 4:00pm.

**All appointments are done on a walk-in basis.**



# Community Health Center of the New River Valley

## Discount Fee Program Application

**\*The Discount Fee Program is only available to Patients whose incomes fall at or below 200% of the Federal Poverty Line.**

How many people are in your family? \_\_\_\_\_  
Please list them below, with the required information for each.

Family Members: (include yourself)	SSN:	Date of Birth:	Relation	Monthly Gross Income*	Employer Name (If employed)

**\*If someone can claim you as a dependent on their taxes, then list all other family members on that tax return.**

**Document and provide proof of all income received:** Paycheck stubs, Retirement, Social Security, Pension, Disability, Worker's Compensation, Unemployment, Child Support, and ALL others not listed.

**Application will be rejected if documentation is not provided.**

Employer Information	Income Information
Employer: _____ Date Employment Began: _____ Employer Phone: _____ Circle One: Full-Time   Part-Time	How often are you paid? _____ Amount you are paid: _____
Unemployment Information	Disability Information
If Unemployed, date employment ended: _____ Does anyone receive unemployment wages? If yes, how much? _____	If Unemployed, has anyone applied for Disability?   Yes / No Is anyone in your family planning on applying for disability? This includes you.   Yes / No
Government Assistance Information	Personal Information
Medicaid? Yes / No   Who? _____ Do you/spouse or any children under 18 receive Social Security Benefits? Yes / No	Did your household file income taxes last year? Yes / No Joint or Single? Circle One.
Insurance Information	
Do you or others in the family have insurance? Yes / No	

The information provided is, to the best of my knowledge and belief, accurate and true. I authorize the release of all information which the Community Health Center may need to determine whether I qualify for financial assistance through their Discount Fee Program.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_