Hope Christian Health Center

Hope Christian Health Center Registration Form

Patient Legal Name (Last, First, Middle):

Home Address:

City: | State: | Zip Code:

Date of Birth: | SSN: | Today's Date:

Phone: | Email:

Patient / Legal Guardian Name(s) if under 18:

1.

2.

Sex at Birth:

☐ Male ☐ Female

Marital Status:

☐ Single ☐ Divorced
☐ Married ☐ Widowed
☐ Partner ☐ Legally Separated

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Gender Identity:

☐ Male
☐ Female
☐ Trans. Male/Female-to-Male
☐ Trans. Female/Male-to-Female
☐ Other
☐ Choose not to disclose

Sexual Orientation:

☐ Lesbian, gay or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Do not know
☐ Choose not to disclose
☐ Something else, please describe: _____

Preferred method of contact:

☐ Call ☐ Email ☐ Text

Do you consent to receive texts from our electronic health record (eCW)? ☐ Yes ☐ No

Languages Spoken:

☐ English ☐ Spanish
Other: _____

Race:

☐ White
☐ Asian
☐ American Indian/Alaska Native
☐ Black/African American
☐ Native Hawaiian/Pacific Islander

Barriers to Communication:

☐ Auditory Impairment
☐ Visual Impairment
☐ Speech Difficulty
☐ Limited English Proficiency
☐ Difficulty Writing
☐ Difficulty Reading

Primary Insurance Name:

Member ID:

Group Number:

Secondary Insurance Name:

Member ID:

Group Number:

Are you a US Veteran?

☐ Yes ☐ No

Do you receive Social Security Disability Insurance? If yes, write the effective date?

_____

Employer Name & Address:

Pharmacy Name & Address:

Living Status:

☐ Rent ☐ Other_____
☐ Own
☐ Living w/ Family or Friend

Do you need help with a Medicaid or SNAP application?

☐ Yes ☐ No

Do you have a living will or Durable Power of Attorney?

☐ Yes ☐ No

In the last 6 months, has lack of transportation kept you from attending medical appointments?

☐ Yes ☐ No

Which income bracket describes your situation best?

☐ < $25,000
☐ $25,501-$45,000
☐ $45,001-$65,000
☐ $65,000-$80,000
☐ > $80,000+

Emergency Contact

Name:

Relationship:

Phone Number:

Hope Christian Health Center - Patient Health

Patient Name:				Date of Birth:	
Significant Illnesses	***Y***	***N***	***Health Screening***	***Y***	***N***
1. Diabetes 1 or 2			4. Mammogram		
2. Cancer: _____			5. Bone Density		
3. High Blood Pressure			6. Colonoscopy		
4. Gout			7. Chest X-ray		
5. Heart Disease			8. Tetanus Vaccine		
6. Kidney Disease			9. MMR Vaccine		
7. Anxiety/Depression			10. TB Test		
8. Stroke/TIA			11. Prostate Exam		
9. Asthma/COPD			12. EKG		
10. High Cholesterol			13. Hepatitis Vaccine		
11. Other: _____			14. Pneumonia Vaccine		
Health Screening	***Y***	***N***	15. Flu Vaccine		
1. Physical			16. Childhood Immunization		
2. Eye Exam			17. Shingles Vaccine		
3. Pap Smear			18. STDS		

Family Medical History (Has any blood relative, including children, had):

History of:	***Y***	***N***	***Relationship***
Anemia			
Cancer			
Diabetes			
Epilepsy			
Heart Disease			
High Cholesterol			
Stroke			
Tuberculosis			
Colon Polyps			
Asthma or COPD			
Drug Abuse			
Alcohol Abuse			
Mental Illness			

Additional Health Behaviors		***Y***	***N***
When was your last dental visit?	Date:		
Do you have a regular sleep schedule?			
Are you exposed to chemicals at work?			

List Allergies	*List Current Medications*
1	1
2	2
3	3

Hospitalizations (List Reasons for Visit)	*Year*
1	
2	
Surgery History	***Year***
1	
2	

Social History	*Y*	*N*	*Frequency*
1. Tobacco			Number of years: _____ Number of cigarettes per day: _____
2. Alcohol			Drinks in a week:
3. Caffeine			Cups in a day:
4. Recreational Drugs			Times used a week:
5. Exercise			
6. Number of Adults and Children in home			Adults: _____ Children: _____
7. Religion			
8. Education Level			

Sexual History	*Y*	*N*	*Additional Info*
Are you sexually active?			
Within the past year?			
With: ☐ Men ☐ Women ☐ Both			
Do you use protection?			
Type: ☐ Condom ☐ Abstinence ☐ Other			
Have you had an STD or STI?			

Spiritual History	*Y*	*N*	*Additional Info*
Do you have spiritual beliefs that help w/ stress?			
Do your beliefs influence your phys. health?			
Are you part of a spiritual community?			
If yes, which one?	Spiritual comm./Church:		
Does this help support you?			
Would you like this addressed in your care?			

PHQ2	*Y*	*N*	*Additional Info*
Over the past 2 weeks have you had little pleasure in doing things?			
Over the past 2 weeks have you been feeling down, depressed and hopeless?			
Do you feel safe in your household?			
Do you have an Advance Directive?			
Would you like an Advance Directive?			

Hope Christian Health Center

Review of Systems

Patient Name:				Date of Birth:	
General	✓	***Men Only***	✓	***Ear, Nose, Throat***	✓
Swollen Glands		Erection Difficulties		Mouth Pain	
Lack of Energy		Lump in Testicles		Jaw Pain	
Fatigue		Sore on Penis/Scrotum		Pain in Teeth	
Fever		Penis Discharge		Sore Throat	
Night Sweats		Other:		Difficulty Swallowing	
Sleep Disturbance		***Gastrointestinal***	✓	Hearing Loss	
Weight Gain		Nauesa		Ringing in Ears	
Weight Loss		Vomiting		Ear Pain	
Allergy/Immunology	✓	Diarrhea		***Neurologic***	✓
Nasal Congestion		Abdominal Pain		Numbness	
Sneezing		Bloody Stools		Dizziness	
Runny Nose		Change in Bowel Habits		Frequent Headache	
Frequent Nosebleeds		Nausea/Vomiting		Memory Loss	
		Constipation		Seizures	
		Endocrine	✓	Tremor	
Women Only	✓	Thyroid Problems		***Respiratory/Cardio***	✓
Abnormal Pap Smear		Goiter		Cough	
Bleeding Between Periods		Frequent Urination		Shortness of breath	
Extreme Menstrual Pain		Abnormal Thirst		Swelling	
Breast Lumps		Change in Appetite		Fast heartbeat	
Nipple Discharge		Delayed Wound Healing		Skipping heartbeat	
Painful Intercourse		***Psychiatric***	✓	***Skin***	✓
Hot Flashes		Anxiety		Acne	
Vaginal Discharge		Depression		Skin Rashes	
Date of LMP: _____		Mood Swings		Skin Lesions	
Date of Pap smear: _____		Suicidal Thoughts		Abnormal Bruising	
Are you pregnant? _____				Itching	
Number of children? _____		***Ophthalmologic***	✓	Concerning Moles	
Last mammogram? _____		Changes in Vision		***Muscle/Joint/Bone***	✓
		Blurred Vision		❑ Arms ❑ Hips ❑ Arthritis	
		Eye Pain		❑ Back ❑ Legs ❑Shoulder	
		Eye Irritation		❑ Feet ❑ Neck ❑Chest pain	
				❑ Hands ❑Joint pain/weakness	

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Authorization to Disclose Medical Information

Patient Name:	Date of Birth:

I voluntarily authorize Hope Christian Health Center to disclose my health information to the recipient that I have identified below:

Name: _____ Relationship: _____ Telephone: _____

Protected or Sensitive Information

I understand that certain information cannot be released without specific authorization as required by State/Federal law:

☐ Drug Abuse Diagnosis/Treatment ☐ Sexually Transmitted Diseases (to include AIDS/HIV)

☐ Alcoholism Diagnosis/Treatment ☐ Mental Health/Treatment

This authorization for release of information covers the period of healthcare from:

☐ (a) _____ to _____

☐ (b) All past, present and future periods.

Right to Revoke: I understand I have the right to revoke this authorization at any time. I understand to revoke this authorization I must do so in writing. I understand that this revocation will not apply to information hat has already been released.

*This form is valid 12 months from the date of signature unless revoked prior to that date.

Signature: _____ Date: _____

Hope Christian Health Center

Office Policies and Financial Agreement

ABOUT US: Our vision is to be a movement of God's people who, in response to His grace, choose daily to promote healing as they take part in the redemptive work of Christ among those who feel economically, socially, and spiritually marginalized in Las Vegas. Hope Christian Health Center (HCHC) provides affordable and excellent healthcare for all. Should you have any questions about our policies please call the office during business hours.

LATE POLICY & CANCELLATIONS: If you arrive more than 15 minutes after your scheduled appointment, we may have to reschedule. Please allow at least 24-hours of notice if you cannot keep your appointment. If you will be unavoidably late, please call and let us know.

CONFIDENTIALITY: We strictly control the access to your information and any violation of such will be a breach of faith. All information provided to any staff member or volunteer is covered by HCHC Confidentiality Policy.

If a copy of your medical records is needed, including labs, X-rays and any other tests, we ask that you give HCHC a 24 hour notice prior picking up your medical records, You will need to sign a release of information form.

HCHC is not a pain management clinic.

REFERRALS: Please allow 7-10 business days for all referrals to be processed.

PAPERWORK: Patient visits are required for Short Term Disability, FMLA and other forms of patient paperwork. Documents will be filled out at your provider's discretion. Please allow up 7 days for documents to be completed.

EMERGENCY CARE: Patients discharged from the hospital are to return to HCHC within 1-2 weeks for follow-up.

INSURANCE: It is the patient's responsibility to provide the clinic with current insurance information. If you are not insured by any medical insurance carrier, please ask about our Sliding Fee Scale Program (SFSP). If your visit requires lab tests, X-rays or other radiology procedures performed outside our facility, these services will be billed to you directly by the provider. We will give the providers all your insurance information.

- I understand that I am responsible for all charges not covered by my insurance company, including these resulting my failure to obtain the necessary referral and/or authorizations from my primary care.
- I hereby authorize HCHC to release information necessary to file and/or process a claim with my insurance company.
- I understand that if cannot pay my bill in full, I am obligated to sign a promissory note.

COPAYMENTS, DEDUCTIBLES & CO-INSURANCE: All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your co-payments, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan. If you're unable to make your payment, please ask about our Sliding Fee Scale Program.

FORMS OF PAYMENT: We accept cash, checks, & credit/debit cards.

PRESCRIPTION REQUESTS:
- Patients requesting new prescriptions or antibiotics must be seen for an appointment by a clinician. They are not prescribed over the phone.
- Please allow 48–72 hours to process prescription requests. Medications requiring pre-authorization may require additional time to process. Please plan ahead for refills during holidays and when traveling.

☐ I hereby grant HCHC authorization to treat and diagnose as deemed medically advisable.

☐ I understand that it is my responsibility to inform the provider at least 72-hours to request for my prescription refills.

We appreciate the opportunity to provide our services to your medical needs. Should you have any questions, please feel free to contact us.

By signing below, I acknowledge that I have read and understand the Office Policies and Financial Agreement.

Patient Signature: _____ **Date:** _____

Patient Name: _____

Hope Christian Health Center

Authorization to Disclose Protected Health Information

Name: _____ DOB: _____ Phone: _____

I hereby authorize any or all of the parties below to release to Hope Christian Health Center my PHI (Protected Health Information), including diagnosis, records of treatment, consultation or examination, diagnostic laboratory testing results, radiology reports, ancillary resting reports, including mental health/substance abuse or HIV/AIDS related treatment rendered to me on the following dates listed below. I understand that Hope Christian Health Center might not be the ordering or referring provider for the above PHI, but as my PCP (primary care provider), I request a copy be disclosed to said provider/office. Authorizing this release of information is voluntary and I may refuse to sign this authorization. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations. I understand this release of information expires after 1 year from the date of signature. This authorization is revocable by me at any time.

Please send the following records as soon as possible for the date(s) _____ / most recent:

☐ All Records	☐ Immunizations	☐ Progress Notes	☐ MRI/CT of _____
☐ Lab Reports	☐ Colonoscopy	☐ Medications	☐ US of _____
☐ Hospital Records	☐ Mammogram	☐ Psychiatric/ Mental Health	☐ X-ray of _____
☐ Pap Smears	☐ History&Physical		☐ Other _____

Please check below which facility we can acquire your medical records from:

Hospitals:

☐ UMC Hospital	☐ Centennial Hills Hospital	☐ Desert Springs Hospital	☐ Valley Hospital
☐ North Vista Hospital	☐ Mountain View Hospital	☐ Mike O'Callaghan Medical Center	☐ Sunrise Hospital
☐ ER @ Aliante	☐ St Rose Dignity Health	☐ Guadalupe Medical Center	

Clinics:

☐ Care Now	☐ Southwest Medical	☐ WHASN: _____(location)
☐ Nevada Health Centers	☐ Healthcare Partners	

Radiology/Laboratory:

☐ Desert Radiologist (DR)	☐ Simon Med	☐ Pueblo Medical Imaging (PMI)
☐ Quest Diagnostics	☐ LabCorp	☐ Steinberg Diagnostic Medical Imaging (SDMI)

Other:

Facility/Provider: _____ Phone: _____ Fax: _____

Facility/Provider: _____ Phone: _____ Fax: _____

Facility/Provider: _____ Phone: _____ Fax: _____

_____ _____

Signature of Patient/Legal Guardian | Today's Date

_____ _____

Print Name of Legal Representative (if applicable) | Relationship to Patient (if not the patient)

4040 N Martin Luther King Blvd, Ste A, North Las Vegas, NV 89032
Office: (702) 644-HOPE I Fax: (702) 902-5443

Hope
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Phone Message Confidential Communication Authorization

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request the method and location for which we communicate confidential information to you. In order to protect the privacy and confidentiality of your information, please complete the following to indicate your preferences for contact and disclosure of confidential information.

By signing below, you authorize the staff of Hope Christian Health Center to call and leave a detailed message on your voicemail, answering machine, or with your designated person. Without your signed consent, the staff may only leave their name and phone number as the message for you to return the call. You have the right to revoke this authorization at any time. Revocation of this authorization must be done in writing. Unless otherwise revoked, this authorization is valid permanently.

_____ _____

Patient Name ***Date of Birth***

Please choose one of the following for the providers and staff:

☐ I DO CONSENT for my healthcare provider to leave detailed telephone messages regarding my personal health information (PHI) using the following options: (Check all that apply).

Patient Home Telephone: _____
(Home Phone Number)

Patient Cellular Telephone: _____
(Cell Phone Number)

Patient Work Telephone: _____
(Work Phone Number)

And / or detailed information may be disclosed to the following designated individual(s):
Name:_____ Relationship: _____ Phone: _____
Name:_____ Relationship: _____ Phone: _____

This will remain in effect until you rescind it in writing.

☐ DO NOT CONSENT for my provider to leave detailed telephone messages regarding my personal health information (PHI).

☐ REVOCATION OF PRIOR CONSENT: I wish to rescind or stop any prior consent to leave detailed telephone messages or communicate with family regarding my personal health information (PHI).

_____ _____

Patient and/or Patient's Representative Signature ***Date***