Hope Christian Health Center

Hope Christian Health Center Registration Form- PEDIATRIC

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
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	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
Preferred method of contact: ☐ Call ☐ Email ☐ Text		
Do you consent to receive texts from our electronic health record (eCW)? ☐ Yes ☐ No	Do you need help with a Medicaid or SNAP application? ☐ Yes ☐ No	Languages Spoken: ☐ English ☐ Spanish Other: _____
In the last 6 months, has lack of transportation kept you from attending medical appointments? ☐ Yes ☐ No	How did you hear about us? ☐ Friend/ Family/ Coworker ☐ Insurance/ Provider List ☐ Health Fair/ Event ☐ Google/ Yelp/ Social Media ☐ Other_____	Primary Insurance Name: Member ID: Group Number:
Do you need help with a Medicaid or SNAP application? ☐ Yes ☐ No	Are you currently experiencing homelessness? ☐ Yes ☐ No	Secondary Insurance Name: Member ID: Group Number:
Emergency Contact: Name: Relationship: Phone Number:		

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Hope Christian Health Center - Patient Health- Peds

Patient's Name:	Date of Birth:	Today's Date:
Reason for Visit:	Date of last physical exam:	Age:

Significant Illnesses	*Y*	*N*	*Birth History*	*Y*	*N*
1. Diabetes 1 or 2			Place of Birth:		
2. Cancer: _____			Baby's Birth Weight: _____ Length:_____		
3. Learning Problems			Any complications with birth?		
4. Asthma			If Yes, please explain:		
5. Rashes			Did you have screenings for infections/birth defects while you were pregnant		
6. Measles/Chicken Pox			If yes, were any abnormal, explain:		
7. Heart Problems			Was it a full term birth?		
8. Ear Infections			Was/has the child been breastfed?		
9. Strep Throat			Was the child injured during labor?		
10. Seizures			Did the child have a seizure after birth?		
11. ADD/ ADHD			Does the Child have birth defects?		
12. Other: _____			-Please include you child's vaccination records-		

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

History of:	*Y*	*N*	*Relationship*
High Blood Pressure			
Stroke			
Diabetes			
Epilepsy			
Heart Disease			
High Cholesterol			
Cancer: If yes, what type? _____			
Mental Illness			
Asthma or COPD			
Other:			

Additional Health Behaviors	*Y*	*N*
When was your last dental visit?	Date:	
Does your child have a regular sleep schedule?		

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

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

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Review of Systems- Peds

Patient Name:				Date of Birth:	
General	✓	***Gastrointestinal***	✓	***Ears, Nose, Throat***	✓
Swollen Glands		Nauesa		Mouth pain	
Lack of Energy		Vomiting		Jaw pain	
Sleep Disturbance		Diarrhea		Pain in teeth	
Fever		Abdominal Pain		Sore Throat	
Night Sweats		Bloody Stools		Difficulty Swallowing	
Rapid weight loss		Constipation		Ear pain	
Rapid weight gain		***Endocrine***	✓	Ringing in ear	
		Thyroid Problems		***Muscle/Joint/Bone***	✓
Allergy/Immunology	✓	Hair Loss		Legs	
Nasal Congestion		Frequent Urination		Feet	
Sneezing		Abnormal Thirst		Shoulder	
Runny Nose		Poor Growth		Back	
Frequent Nosebleeds		Change in Appetite		Hips	
Medication/ Food Allergy		Delayed Wound Healing		Neck	
				Arms	
Skin	✓	***Hematology***		Hands	
Acne		Bleeding		***Respiratory/Cardio***	✓
Concerning Moles		Bruising		Cough	
Itching		Enlarged Glands		Shortness of breath	
Skin rashes/ lesions				Cold/blue hands	
				Fast heartbeat	
Genitourinary	✓	***Psychiatric***	✓	Skipping heartbeat	
Pain with urination		Anxiety/ Stress		Chest pain/pressure	
Blood in Urine		Concerns with Attention			
Increased Urine Frequency		Concerns with Impulsivity			
Abnormal Discharge		Depression Symptoms		***Neurologic***	✓
				Developmental Concerns	
		Ophthalmologic	✓	Dizziness	
		Changes in Vision		Frequent Headache	
		Blurred Vision		Faints/Blackouts	
		Eye Pain		Seizures	
		Eye Irritation		Memory loss	

Hope
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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: _____
(Signature of Patient/Legal Guardian)

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. The staff at HCHC are designated as mandated reporters when there is suspicion that a client or another named victim is the perpetrator, observer, or actual victim of physical, emotional, sexual abuse, or neglect. We are also mandated reporters in cases of threats or attempts to commit suicide, grave bodily harm, or death to another person, or if an individual conducts themselves in a manner where there is a substantial risk of incurring serious bodily harm.

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 to 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 to 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 those resulting my failure to obtain the necessary referral and/or authorizations from my primary care.
- I hereby authorize HCHC to release the information necessary to file and/or process a claim with my insurance company.
- I understand that if I 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.

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

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

Patient Name:_____ **Date:** _____

Signature of Patient/Legal Guardian:_____

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
☐ North Vista Hospital	☐ Mountain View Hospital	☐ Valley Hospital
☐ ER @ Aliante	☐ St Rose Dignity Health	☐ Sunrise Hospital

Clinics:

		☐ WHASN: _____(location)
☐ Care Now	☐ Southwest Medical	☐ Guadalupe Medical Center
☐ Nevada Health Centers	☐ Healthcare Partners	☐ Mike O'Callaghan Medical Center

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 Christian Health Center

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: _____

<u>This will remain in effect until you rescind it in writing.</u>

☐ I 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***