HCHC
HEALTHY COMMUNITY HEALTH CENTERS

Stone Port— 1380 Little Sorrell Dr, Harrisonburg
Park View— 1479 Virginia Ave, Harrisonburg
Elkton— 800 Shenandoah Ave #170, Elkton

Phone: (540) 433-4913
Fax: (540) 433-4915
www.hburgchc.org

CONSENT TO SERVICES AND CARE

Initial below

CONSENT FOR TREATMENT

I consent to receive treatment at Healthy Community Health Centers (HCHC). When requested, I will provide all information regarding previous illness or injury, medical history, current medications, and pertinent medical records. I understand that HCHC provides services without regard to race, color, religion, sex (including pregnancy, gender identity, and sexual orientation), national origin, age, disability, or genetic information.

_____

FINANCIAL AGREEMENT

I authorize direct payment to HCHC for any medical care received. I consent to allow HCHC to file claims on my behalf. I understand that I am responsible for services not covered by my insurance plan, as well as services rendered when my insurance was not in effect.

_____

NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING

I attest I have been informed of Virginia state code 32. 1-45.1 regarding blood testing. In the event that a provider or employee is exposed to my bodily fluids in a manner which may transmit disease, I will be deemed as consenting to testing for HIV and Hepatitis and to the release of the test results to HCHC who will cover the cost of testing.

_____

NOTICE OF PRIVACY PRACTICES

_____ I have read and understand HCHC's Notice of Privacy Practices and have been offered a copy, if desired.

MEDICAL INFORMATION

HCHC participates with Virginia's Prescription Monitoring program which contains information regarding prescriptions I have been given from outside sources. I give HCHC permission to obtain my medical records for any relevant hospitals, medical practices or pharmacies where I have received services to optimize safe patient care. In order to transfer my records from a previous provider, staff will provide me with an authorization for the release of protected health information.

_____

APPOINTMENT CANCELLATION

In the event you need to cancel or reschedule your appointment, we ask that you notify us with at least 24 hours in advance of your appointment so we are able to help other patients who are waiting to be seen. To help you remember future appointments, we offer an automated appointment reminder system and an online Patient Portal.

_____

PAIN MANAGEMENT

HCHC manages chronic pain with non-opiate and non-controlled substances. We will assist you with pain management alternatives.

_____

PRESCRIPTION REFILLS

Do not wait until you are completely out of your medication to request a refill. For medication refills, please call your pharmacy to request a refill. Please allow at least 2 to 3 business days for your refill to be available at your pharmacy.

_____

FAMILY PLANNING SERVICES

These services are completely voluntary and not a prerequisite for the receipt of any other services that HCHC offers.

_____

I agree this permission will be valid until taken away in writing or replaced by one of a later date. A photocopy of this agreement will be considered effective and as valid as the original. A copy of this form is available to me upon request.

Patient Signature: _____ **Date:**____ /____ /_____

Parent/Guardian Signature *(if applicable)*: _____

Print Name: _____ **Relationship to Patient:** _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____ **SSN:**_____-____-_____

Preferred Name: _____ **Pronouns:**_____ **Date of Birth:**____ /____ /_____

Sex Assigned at Birth: ____Female _____Male **Marital Status:** O Single O Married O Divorced O Widowed O Other

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Physical Address:_____
(if different than your mailing address)

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____**Work Phone:**_____

Tell us where to call you, leave you messages and appointment reminders: O Home O Cell O Work O Other_____

Can HCHC leave messages on the phone numbers provided? O Yes, brief messages O Yes, extended messages O No messages

E-mail Address: _____ **Sign-Up for Patient Portal?** O Yes O No
(HCHC will not share this contact information with any other entities)

RESPONSIBLE PARTY
(person to be billed if other than the patient)

Last Name:_____ **First Name:** _____ **Date of Birth:**____ /____ /_____

Mailing Address: _____
(if different from patient)

City:_____ **State:** _____ **Zip:**_____

Primary Phone: _____ **Relationship to the Patient:**_____

Please list all individuals with whom we may discuss your medical care **(HIPAA).** The individuals on this list will also be part of your emergency contact. **We will not discuss your medical care with anyone NOT listed below.**

Name (First and Last):_____**Phone:** _____**Relationship:** _____

Name (First and Last):_____**Phone:** _____**Relationship:** _____

Name (First and Last):_____**Phone:** _____**Relationship:** _____

Additional agent and/or guardianship legal documentation is required to permit an individual to sign a Request of Information (ROI) on behalf of a non-minor patient.

Patient Name: **Date of Birth:**

Additional Information

As a Federally Qualified Health Center (FQHC), HCHC is required to collect the following information.
Your responses will remain confidential. **THANK YOU** in advance for your assistance.

Race

- O White (including Latino/Hispanic Descent)
- O Black or African American
- O Other Pacific Islander
- O Guamanian or Chamorro
- O Samoan
- O Asian American
- O Chinese
- O Filipino
- O Japanese
- O Korean
- O Vietnamese
- O Other Asian
- O American Indian/Alaska Native
- O Native Hawaiian
- O More than one race

Ethnicity

- O Not Hispanic, Latino/a, or Spanish origin
- O Mexican, Mexican American, Chicano/a
- O Puerto Rican
- O Cuban
- O Another Hispanic, Latino/a, or Spanish origin
- O Total Hispanic, Latino/a, or Spanish origin
- O Unreported/Choose Not to Disclose Ethnicity

Will you need an interpreter?
O Yes O No

Primary Language Spoken:
_____

Housing

Type:
- O Single Family
- O Multi-Family
- O Apartment
- O Other

Living Situation:
O Public Housing O Homeless O Not Applicable

If homeless, please indicate a start date and type:
Start Date: _____
O Shelter O Transitional
O Street O Doubling Up

Sexual Orientation

- O Straight
- O Lesbian, Gay, or Homosexual
- O Bisexual
- O Something Else _____
- O Do Not Know
- O Choose to not disclose

Gender Identity

- O Male
- O Female
- O Transgender Male/Female-to-Male
- O Transgender Female/Male-to-Female
- O Genderqueer, *neither exclusively male nor female*
- O Other
- O Choose to not disclose

Are you or a family member a Migrant Farm Worker?
O Yes O No

Are you or a family member a Seasonal Farm Worker?
O Yes O No

Are you a veteran of the US Armed Forces?
O Yes O No

Transportation

Is transportation to appointments difficult for you? O Yes O No
What is your primary mean of transportation? _____

Income Level

Family Size *(Includes all claimed dependents)*: O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O Other_____

Total Annual Household Income *(Write in one of the following):*

Annual: _____ Monthly: _____

Biweekly: _____ Weekly: _____

Follow HCHC (@HealthyCHC) **on social media for updates, announcements, and other news.**

This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.

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