Community Health Center

Family	Last First Middle	Birth date	Sex M-F	Race	Marital Status	Social Security #
Patient						
Responsible Guardian						
Significant other						

Address: ________________________________ **City:** _________________________________**State:** ___________

Zip Code: _______ **County:** _____________________ **Telephone (H)** _________________ **(W)** ________________

Cell ___________________**Email Address:** ____

Responsible Party Arrangement (proof of Custody Agreement/Dependent Adult Guardianship may be requested):

#1 Parent Name: ____Phone: _____________________________
Custody (circle): Primary / Secondary / Equal / Suspended / Terminated

#2 Parent Name: ____Phone: ______________________________
Custody (circle): Primary / Secondary / Equal / Suspended / Terminated

Guardian: ____Phone: _____________________________

Description of Legal Authority: ____

Military Status: **None□ Active□ Retired□ Veteran□** **Student Status:** **None□ Part-time□ Full-time□**
Hispanic/Latino Ethnicity: **Yes □ No □**
Housing Status: **Own□ Rent□ Live with friends/family □ Homeless □**
*If you rent do you receive rental assistance (HUD, MIRHA, Shelter plus Care, other)? **Yes □ No □**

If employed, please let us know where____________________ **Full Time□ Part Time□ Self Employed□ Retired□ Unemployed□**

TURN OVER TO COMPLETE REGISTRATION

DO YOU WISH TO BE EVALUATED FOR A DISCOUNT? **YES NO**

If yes, please ask for information about income verification from our Financial Advocate.

Please estimate your income information below. **We only collect this information for our federal grant purposes to continue to receive funding for those who are uninsured and need our services.** Please help us in maintaining our safety net services for those who need medical care. Your name will not be used when reporting for our grant purposes, nor will it be shared with any other entity. Please check your income level according to your household size.

Household Size			Monthly Income Level		
1	< $1,256	< $1,670	< $2,084	< $2,510	$2,511 +
2	< $1,704	< $2,266	< $2,829	< $3,407	$3,408 +
3	< $2,153	< $2,863	< $3,573	< $4,303	$4,304 +
4	< $2,601	< $3,459	< $4,317	< $5,200	$5,201 +
5	< $3,049	< $4,055	< $5,061	< $6,097	$6,098 +
6	< $3,498	< $4,652	< $5,805	< $6,993	$6,994 +
7	< $3,946	< $5,248	< $6,550	< $7,890	$7,891 +
8	< $4,394	< $5,844	< $7,294	< $8,787	$8,788 +

How did you hear about us?

□ Television □ Radio □ Newspaper □ Brochure □ Patient/Physician Referral □ Social Media □ Other: ______________________________

How would you like us to contact you about appointments? **Phone Call or Text**

I authorize CHCFD to leave a detailed message on my phone (circle one)**:** **Yes No**

Emergency Contact Name (Person to contact in an emergency NOT living in your household

Name: ______________________________Telephone: ________________________Relationship: ______________

I authorize CHCFD to release my general information to the following:

(Example: appointment times/pick up prescriptions/book or cancel appointments)

Name: ______________________________Telephone: ________________________Relationship: ______________

Name: ______________________________Telephone: ________________________Relationship: ______________

Payment Agreement: I hereby certify that the above information is true and that I have reported all sources of income being received to support my family. I agree to promptly and fully pay any charges for services supplied and provided by Community Health Center of Fort Dodge, Inc. according to the fees established. **I agree to promptly pay for charges considered non covered or my responsibility by my insurance companies after the claim has been processed**. In the event of non-payment, failure to comply with terms of my payment plan or do not make a payment plan, I will be responsible for any late fees associated with my past due bill. I have read all the above terms and hereby assume responsibility for paying any charges according to these terms.

Assignment of Benefits: I hereby assign and authorize direct payment to Community Health Center of Fort Dodge, Inc. of all insurance coverage or other benefits under any government program, any insurance policy or plan, or any other available benefit. This assignment shall remain in effect until revoked in writing.

Consent to Treatment: I hereby request and give consent for the health care professionals at Community Health Center of Fort Dodge, Inc. to provide treatment to me and/or my family.

Consent to Release Protected Health Information: I authorize Community Health Center of Fort Dodge, Inc. to release medical information relating to the patient to health insurance companies, health plans or third-party payers, or their authorized agents, for the purpose of determining benefits payable in connection with services provided.

Community Health Center of Fort Dodge is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Community Health Center of Fort Dodge, OCHIN supplies information technology and related services to Community Health Center of Fort Dodge and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Community Health Center of Fort Dodge with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement. Our clinic may use AI-powered tools to enhance your care, but all decisions are reviewed by your healthcare provider.

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice or Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this notice.
- The person to contact for further information about our privacy practices is our security officer.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices:

____

Patient Date of Birth

____

Patient Name (printed) Date

____

Patient or Responsible Party Signature Date

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Description of Legal Authority to Act on Behalf of Patient

Full Privacy Practice is available upon request.

Document Revised February 2025

Community Health Center of Fort Dodge, Inc.

Missed Appointment Agreement

____ ___________________________

Printed Patient Name **Birthday**

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or late canceling an appointment means we are unable to fill this appointment time with another patient who desperately needs care.

Our policy requires **(initial each box after reading)**:

☐ **Appointment Confirmation**: You must text/call to confirm your appointment the business day before. Our practice closes at 5:00pm. It is your responsibility to call. If you do not call to confirm we will give your appointment away to another patient. This will be considered a missed appointment.

☐ **Timely Cancellations**: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment.

☐ **On Time Arrivals**: If you are more than 15 minutes late to your appointment, we may give your appointment away to another patient. This will be considered a missed appointment.

☐ **Compliance:** Patients are only allowed THREE missed appointments in a 12-month period. After the third missed appointment, you will not be scheduled appointments, but are welcome to use our clinic as a "same-day" patient.

Many patients use Community Health Center of Fort Dodge Inc. services.
Your help in keeping your appointments enables us to provide better and timelier care for all our patients.

____ _________________________

Patient or Parent/Guardian Signature ***Date***

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Description of Legal Authority to Act on Behalf of Patient