Southeast Community Health Systems
Medical Patient Registration

Emailcompletedregistrationformto
schoolregistration@shchc.org

PATIENT INFORMATION

Last Name | First Name | MI | DOB | SS#

Street Address | City | State | Zip | County

CONTACT INFORMATION

Primary Phone Number □ Home □ Cell □ Work

Secondary Phone Number □ Home □ Cell □ Work

Do you need transportation? □ **Yes** □ **No**

Email:

PATIENT DEMOGRAPHICS

Primary Language Spoken
□ English □ Spanish □ Other_____

Would you like an interpreter?
□ Yes □ No

Race (Check all that apply)
□ American Indian/Native Alaskan
□ Asian Indian □ Black/African American
□ White
□ Chinese □ Filipino □ Korean
□ Japanese □ Vietnamese □ Other Asian
□ Native Hawaiian
□ Guamanian or Chamorro
□ Other Pacific Islander
□ Other
□ More than one race

Ethnicity
□ Non-Hispanic, Latino or Spanish Origin
□ Cuban □ Puerto Rican
□ Mexican, Mexican American or Chicano
□ Samoan □ Yes, Another Hispanic or Spanish, origin
□ Unreported/Refused to disclosed ethnicity
□ Unreported/Choose not to disclose race

Place of Birth

City_____

State_____

Marital Status
□ Single
□ Married
□ Divorced
□ Widowed
□ Separated
□ Life Partner

Student
□ Full-Time
□ Part-time
□ Not a Student, highest grade completed?
_____

Employment Status
□ Full-Time
□ Part Time
□ Not Employed □ Retired
□ Disabled
□ Student
□ None

Agriculture Status
□ Migrant Worker
□ Seasonal
□ Dependent of Migrant
□ Dependent of Seasonal

Employer **Phone No.**

Housing Status: □ Not Homeless □ Homeless
□ Other □ Doubling Up □ Public Housing □ Transitional
□ Street □ Homeless Shelter

Primary Care Provider

Pharmacy_____

Phone No. _____

Military Veteran
□ Yes
□ No

GUARANTOR (Person To Be Billed, Check here if same as patient ☐)

Last Name | First Name | MI | DOB | SS#

Street Address | City | State | Zip | Home Phone | Cell Phone

EMERGENCY CONTACT (*Someone outside of your home that we may contact in an emergency*)

Last Name | First Name | Relationship

Street Address | City | State | Zip | Home Phone | Cell Phone

NEXT OF KIN *(check here if same as emergency contact* ☐

Last Name | First Name | Relationship

Street Address | City | State | Zip | Home Phone | Cell Phone

Southeast Community Health Systems

FAMILY INCOME INFORMATION

We request income on all patients for governmental reporting purposes.
If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application

Income Period: □ Weekly □ Bi-weekly □ Monthly □ Quarterly □ Annually □ Other _____
Gross Household Income: $_____ Number of individuals income supports: _____

INSURANCE INFORMATION

Please allow our staff to copy/scan your insurance card

PLAN # 1 Information

Insurance Company: _____
Member ID #:_____ Group #:_____
Patient's Relation to Subscriber: □ Self □ Child □ Parent □ Spouse □ Employer □ Other_____

**********If Patient is Subscriber (No need to complete the rest of this section)**********

First Name:_____ Middle Name:_____ Last Name:_____
Suffix:_____ Social Security Number:_____ Gender: □ Male □ Female
Date of birth (mm/dd/yyyy): _____
Street Address:_____ City:_____ State:_____
Zip:_____ Home Phone:_____ Mobile/Cell Phone:_____

PLAN # 2 Information

Insurance Company: _____
Member ID #:_____ Group #:_____
Patient's Relation to Subscriber: □ Self □ Child □ Parent □ Spouse □ Employer □ Other_____

**********If Patient is Subscriber (No need to complete the rest of this section)**********

First Name:_____ Middle Name:_____ Last _____Suffix:_____
Social Security Number:_____ Gender: □ Male □ Female
Date of birth (mm/dd/yyyy): _____
Street Address: _____ City: _____ State: _____
Zip: _____ Home Phone: _____ Mobile/Cell Phone: _____

INSURANCE ASSIGNMENT: I assign directly to Southeast Community Health Systems (SCHS) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize SCHS to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions and for a copy for this statement and my signature to be kept on file and used in place of this original.

Patient/Guarantor Signature _____ Date: _____/_____/_____

Sliding Fee Scale Application

Date: / /

First Name: Middle Name: Last Name:

Household Size				
Name	Relationship	Date of Birth	Social Security Number	Income
	Head of Household			

Total Gross Income:$ _____

NOTE: To comply with federal regulations, to give you a discount on our medical-dental services, it is necessary for us to ask some personal questions. Your answers will be kept on file and strict confidence. You must verify you income annually. Please bring yearly income tax return, last month's paycheck stubs, copies of your social security-food stamps award letters, or other supporting documents you may receive as proof of family income. Only the family size and annual gross income will be used to determine your eligibility and calculate your discount.

Sliding Fee Scale Discount Rates (Copy of Sliding Fee Scale available upon patient's request)

Medical Nominal Fee for Scale "A" - $30 for new patients
$25 for established patients

Dental Nominal Fee for Scale "A"- $50 f new and established patients

All other office visits and/or procedures are discounted at the following percentages:
B-50% Discount
C-35% Discount
D-20% Discount
E- 0% Discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Southeast Community Health Systems if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Southeast Community Health Systems. I hereby acknowledge that I read the foregoing disclosure and understand it.

Last Name _____First Name _____

Signature of Patient or Guardian _____ Date _____/_____/_____

Southeast Community Health Systems

Patient Name: _____ **Birth date:** _____/_____/_____**Date:**_____/_____/_____

GENERAL CONSENT FOR TREATMENT

1. I hereby authorize and consent to all necessary medical procedures needed for diagnosis and treatment for me and/or my dependents by Southeast Community Health Systems (SCHS).
2. I understand that no guarantee or assurance has been made as to the results that may be obtained.
3. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees of a cure have been made to me as a result of examinations or treatments by SCHS.
4. I give permission to release to my insurance company medical information necessary in the filing of lawful claims by SCHS' staff for services rendered by SCHS to me or my dependents.
5. I hereby authorize payment directly to SCHS of benefits relative to pending claims and/or Major Medical benefits otherwise payable to me, not to exceed SCHS' regular charges for this service.
6. I certify that the information that I have provided in applying for payments under Title XVII of the SSA Act is correct. I authorize any holder of medical or other information intermediaries, carriers, or any other insurer, any information needed for this or any related Medicare/Medicaid Claims. I request benefits be paid on my behalf.
7. I agree that a photocopy of this form is as valid as the original.
8. I agree and understand that the medical records are the property of SCHS; however, I can request a copy for a nominal fee at any time.
9. I certify that the information provided is true to the best of my knowledge.
10. Louisiana law (R.S. 40:1079.1) permits minors to self-consent for certain services (illness/disease, STIs, substance abuse) . In those cases, parental notification is at the provider's discretion.
11. Louisiana SBHCs are required to obtain a separate consent for immunizations.

Signature of Patient (or Guardian): _____Date: _____

PATIENT RIGHTS

I have received, read and understand my rights and responsibilities as a patient of Southeast Community Health Systems and understand that if the quality of my care is compromised and if SCHS management staff or quality assurance committee cannot address it in a timely fashion, I have the option to report the healthcare compromise to the Joint Commission at (800) 994-6610, or email Complaint@jointcommission.org. _____

PATIENT RIGHTS Signature of Witness (when patient requires reading of rights): _____ _____ _____

PATIENT RESPONSIBILITY

1. I acknowledge that I am fully responsible for any and all expenses incurred at Southeast Community Health Systems for myself and/or dependents/family members.
2. I understand that all payments are due at the time of service.
3. I understand that all payments must be made towards any outstanding balance in addition to the payment for the current date of service rendered.

Signature of Patient (or Guardian): _____ Date: _____

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

I understand that Southeast Community Health Systems does not honor Advanced Directives. In the event of a medical emergency during the clinic visit, first aid measures will be provided, 911 called and hospital transfer initiated.
In emergencies, the SBHC is required by law to provide treatment to a student, and every attempt is made to contact the parent/legal guardian _____

Signature of Patient: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.
I wish to place the following restrictions on disclosure of my health information (Please list below or write N/A if no restrictions):

_____/_____/_____

Signature: _____ Date: _____

Relationship to patient if not signed by patient: _____

Southeast Community Health Systems
MEDICAL HISTORY

Patient Name: _____ **Birth date:** _____/_____/_____ **Date:**_____/_____/_____

Past and Present Illness	Surgery	Family History (state which family member has illness)
○ Diabetes ○ High Blood Pressure ○ Heart Disease ○ Cancer ○ Seizures ○ Anemia ○ Asthma ○ Frequent ear infections ○ Frequent bladder infections ○ STDs ○ ADHD ○ Anxiety ○ Depression ○ Developmental delays ○ Other:_____	○ Tonsils ○ Adenoids ○ Appendix ○ Gallbladder ○ Heart ○ Thyroid ○ Stomach ○ Hernia ○ Ear tubes ○ Other: _____ _____ _____ _____	Diabetes _____ Heart Attack _____ High Blood Pressure _____ Stroke _____ Seizures _____ Glaucoma _____ Thyroid Disease _____ HIV/AIDS _____ Mental illness _____ Migraines _____ Kidney Disease _____ Arthritis _____ Cancer (indicate type) _____

Do you live with someone who has Tuberculosis (TB)? __ Yes __ No
Do you live with someone who has Hepatitis? __ Yes __ No
Do you live with fear of abuse or violence in the home? __ Yes __ No
Do you live with anyone who smokes or uses drugs? __ Yes __ No
Do you live with someone who has HIV? __ Yes __ No

Preferences for Learning:
_____Written
_____Visual
_____Verbal
_____Demonstrated

Languages
Language spoken:_____

Barriers
Language: _____
Reading: _____
Hearing: _____
Vision: _____

Do you exercise?_____

Do you watch fat, salt, cholesterol in your diet?_____

Do you have any other problems SCHS should be aware of?

_____

Is there anything a school counselor could help support your child with? _____

Current Medications: _____

List of Allergies: _____

Cultural Beliefs: _____

Appointment Confirmation & Cancellation Policy

We understand that unplanned issues can come up, and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be canceled at least 24 hours in advance. Our providers want to be available for your needs, and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancelation policy, circumstances have caused us to enforce our revised policy.

Cancellation Policy

After the second missed appointment or no show, the patient will not be allowed to schedule an appointment with our office for 6 months. The patient can only have same day appointments if available.

Confirmation Policy

If a patient does not confirm their appointment within 24 hours of the appointment time, they will be taken off the schedule, and their appointment slot will be filled.

As of March 8, 2017, this policy is effective. Thank you for being a valued patient, and for your understanding, and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

_____	_____	____/____/____
Printed name	Signature	Date

Albany 225.306.2050
Greensburg 225.306.2070
Independence 225.306.2060
Kentwood 225.306.2100
Zachary 225.306.2000
Picardy 225.763.4990

The **Southeast Community Health Systems** Patient Portal provides an easy-to-use, secure, web-based method for patients to access portions of their medical records on-line. This is available from any computer (desktop, laptop or tablet) with Internet access. When you log into the **Southeast Community Health Systems** Patient Portal, you will be able to view information, including your medical conditions, medications, vital signs, lab results, allergies, and insurance policies.

Register for the Southeast Community Health Systems Patient Portal

Use this form to request a **Southeast Community Health Systems** Patient Portal account.
Once you have been registered for the **Southeast Community Health Systems** Patient Portal, you will receive an email from **Southeast Community Health Systems** with instructions to complete your Patient Portal registration.

Patient Registration Form

By completing this form, you are authorizing to set up a *Southeast Community Health Systems* Patient Portal Account.

Please complete using CAPITAL LETTERS with one character in each block.

FIRST NAME:	
LAST NAME:	
DATE OF BIRTH:	/ /
Last 4 Digits of SSN	
EMAIL ADDRESS:	
ZIP (Postal) Code #	-
Signature:	
Today's Date	/ /

☐Yes, I would like to be enrolled in the Southeast Community Health Systems Patient Portal.

Please allow 3 business days for your request to be processed.
A Southeast Community Health Systems representative may contact you to verify your information.

SOUTHEAST COMMUNITY Health Systems
Health, Vitality, & Wellness

Patient Name:_____
Date of Birth:_____
Today's Date:_____

Patient Health Questionaire

Over the past 2 weeks, How often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:

0 = Not at all
1= Several Days
2= More than half the days
3= Nearly every day

Feeling Down, Depressed, or hopeless:

0 = Not at all
1= Several Days
2= More than half the days
3= Nearly every day

CAGE-AID Questions (Adapted)

1. Have you ever felt you should cut down on your drinking? or drug use? (Yes / No)
2. Have people annoyed you by critisizing you drinking? Or drug use? (Yes / No)
3. Have you felt bad about your drinking or drug use? (Yes / No)
4. Have you ever had a drink or used drugs firt thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? (Yes / No)