

# Central Health Center

Please Print

## PATIENT INFORMATION SHEET Please Complete in Full

Chart# \_\_\_\_\_

Print Name \_\_\_\_\_  
Last First Middle Maiden

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_

Home # \_\_\_\_\_ Best time \_\_\_\_\_

Mailing Address \_\_\_\_\_

Cell # \_\_\_\_\_ to call \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I work:  Full time  Part time  I do not work Place of Work \_\_\_\_\_

I attend school:  Full time  Part time U.S. Veteran Yes \_\_\_ No \_\_\_ Family member of Veteran Yes \_\_\_ No \_\_\_

Work phone \_\_\_\_\_ Best time to call \_\_\_\_\_  E-mail address \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_ Cell# \_\_\_\_\_

Spouse / Partner Employment: \_\_\_\_\_ Phone # \_\_\_\_\_

I live with:  Spouse / Partner  Parents  Others  Alone

How many people live in your home? \_\_\_\_\_ How many living with you are 18 years or younger or students? \_\_\_\_\_

We must be able to contact you to give you test results. Please check all the ways we may contact you:

Call home  call work  Mail at home  Plain envelope  E-mail  Texting  Other

How did you learn about us?  Friend / Family  Radio  Newspaper  Internet / Website  Facebook  Yellow Pages

Billboard  Other \_\_\_\_\_

**Because we receive federal funds, we must collect this information about you:**

**Please check race:**  White  African American / Black  American Indian / Alaskan Native  Asian  
 Pacific Islander / Native Hawaiian  More than one race  Other

**Please check ethnicity:**  Hispanic / Latino  Non-Hispanic / Non-Latino

Are you covered by public health insurance such as Medicaid, Medicare, CHIP, TRICARE / CHAMPUS, CHAMPVA or Kids Connection?  Yes  No  Unknown

Are you covered by private insurance?  Yes  No  Unknown

Does your insurance cover reproductive health services?  Yes  No  Unknown

Are you able to read written English?  Yes  No Are you able to understand spoken English?  Yes  No

Do you have an executed Advance Directive?  Yes  No (If yes, please provide copy)

I have been offered a copy of the Privacy Practices for Central Health Center.

I request a copy of the Privacy Practices.  I do not desire a copy of the Privacy Practices.

Bill my insurance.  Bill Medicaid # \_\_\_\_\_  I do NOT wish to apply for reduced fees.

I wish to apply for reduced fees and will provide complete and honest information about my income.

**LIST ALL SOURCES OF FINANCIAL SUPPORT WITHIN YOUR HOME** (show all amounts before any deductions)

**In order to receive reduced fees, this must be filled out.**

- Your employment monthly amount: \_\_\_\_\_
- Spouse / partner or parent employment \_\_\_\_\_
- Income of others 18 years or older \_\_\_\_\_
- Dependent children (AFDC / ADC) \_\_\_\_\_
- Child support and / or alimony \_\_\_\_\_
- SSI, unemployment compensation \_\_\_\_\_
- Social Security, pension, railroad retirement, insurance, annuity payments \_\_\_\_\_
- Dividends, interest, rental income, trust funds \_\_\_\_\_
- Other sources (tips, allowances, etc.) \_\_\_\_\_

How many people, including yourself, does this income support? \_\_\_\_\_

Of these persons, how many are 18 years or younger, or student? \_\_\_\_\_

Are you being claimed on your parent's tax return?  Yes  No

Cost for services is based on a sliding fee scale. You are responsible for any fees which may apply.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**ASSURANCE OF CONFIDENTIALITY:** This medical record is confidential and will not be released to anyone with out your written consent except as may be required by law.

**Office Use Only:**

VERIFIED TOTAL MONTHLY INCOME \_\_\_\_\_

INCOME CODE: A(1) B(2) C(3) D(4) E(5) F(6)

CAREFUL CONTACT Yes \_\_\_ No \_\_\_

3rd party: INS Medicaid EWM-1 EWM-2

**CENTRAL HEALTH CENTER  
PRIVACY PRACTICES ACKNOWLEDGEMENT**

**ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices for Central Health Center and I have been provided an opportunity to review it. I acknowledge the information below is a brief summary of the Privacy Practices given me.

Name: \_\_\_\_\_ Pt. #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ASSURANCE OF CONFIDENTIALITY:**

**Your medical record is confidential and will not be released to anyone without your written consent except as may be required by law.**

Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Nebraska partnership for Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information.

**Central Health Center may access, use and share medical information for purpose of:**

- Treatment
- Payment
- Operations

**Other permitted uses and disclosures that may be made without consent may be those for:**

- |                            |  |   |
|----------------------------|--|---|
| • As Required By Law       | • Legal Proceedings                                  | • Criminal Activity   |
| • Public Health Activities | • Law Enforcement                                    | • Military Activity and National Security                               |
| • Communicable Diseases    | • Workers Compensation                               | • Food and Drug Administration  |
| • Health Oversight         | • Research   | • Inmates   |
| • Abuse or Neglect         | • Coroners, Funeral Directors,<br>And Organ Donation | • Required Uses and Disclosures for<br>Investigative Compliance Reasons |

**Your rights to privacy:**

- Right to Inspect and Copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions (CHC is not required to agree)
- Right to Request Confidential Communications

Central Health Center reserves the right to amend its Privacy Practices at any time and will provide notice of any material change or revision of these practices.

I understand my written consent is required for the release of my medical information, except as may be necessary to provide services to myself or as noted above with appropriate safeguards for confidentiality. When information is requested, CHC shall release only the specific information requested. Information collected for data reporting purposes will be disclosed only in summary, statistical, or other form, that does not identify particular individuals. Upon signed written request, patients transferring to other providers may have their records transferred to expedite continuity of care.

You can also provide us written authorization to use your medical information for other purposes; you may revoke that permission, in writing, at any time.

**Grand Island**  
217 E. Stolley Park Rd, Ste E  
PO Box 2539  
Grand Island, NE 68801  
PH 308-384-7625  
TF 888-308-2134  
FX 308-384-8904

**Kearney**  
4503 2<sup>nd</sup> Ave Ste 209  
PO Box 338  
Kearney, NE 68848  
PH 308-234-9140  
TF 888-308-2135  
FX 308-236-5814

# CENTRAL HEALTH CENTER

## PATIENT INFORMATION & FINANCIAL POLICY

### WELCOME

The staff of Central Health Center (CHC) welcomes you to our clinic. Your healthcare is our primary concern. We hope the information provided answers your questions about our services, policies, and procedures.

### CELL PHONES

Out of consideration for other patients, please turn your cell phone off or put it on vibrate while you are in the clinic. **IF YOU MUST TAKE A CALL** while we are helping you, you may be asked to step aside while we assist the next patient, which may delay or prolong your visit to see one of our providers.

### APPOINTMENTS

We strive to see all patients in accordance with their scheduled appointment. However, please understand that not all patients require the same amount of time with the provider and that emergencies do occur, so some delays are unavoidable. If and when delays occur, we will do our best to keep you informed. Your patience in these situations is greatly appreciated. In the event, you are unable to keep your scheduled appointment, you are required to notify us a minimum of two hours prior to the scheduled appointment to avoid a thirty (\$30.00) No Show Fee. If you have two no shows in the same calendar year, any appointments thereafter in that same calendar year shall be on a walk-in basis only, in which you will be seen between or after other scheduled appointments are complete. If you have an unpaid balance from a previous No Show Fee or Service Fee, you shall remain on a walk-in status until your No Show and/or Service Fees are paid in full. By keeping us informed of changes in your schedule, allows the CHC to provide our patients with quality services in a timely manner, while preventing you from being charged an additional no show fee. Title X Family Planning Services shall not be subject to any no-show fee and shall not be placed on a walk-in status.

### REGISTRATION

On your visit to CHC, you will be asked for basic information to establish your medical record and financial account. It is essential that you bring with you your current insurance information at that time and notify our office of any changes in name, address, phone number, or insurance as soon as they occur. You shall provide an active alternative contact phone number that shall be used in the event of a health emergency or financial obligations. The alternative contact phone number may be verified prior to your departure from Central Health Center.

### FEES

Our patients have the option to apply for reduced fees. If you wish to apply for reduced fees, you will need to supply our office with appropriate documentation of household income. If you do not provide supporting documentation, you shall be charged appropriately with the information received from your self-declaration form for up to thirty (30) calendar days. Failure to provide appropriate documentation reflecting your household income within the first thirty (30) calendar days shall result in your current and future services being billed at full pay. If you are to provide supporting documentation reflecting your household income on day thirty-one (31) or later, your charges may be re-assessed at the appropriate household income, however, a Service Fee of forty (\$40.00) shall be charged. Our charges for services and office visits are based upon the complexity of services and the time spent treating you. This may include charges for testing and supplies. Clinic staff will be glad to discuss our fees with you. You shall not be denied Title X services due to the inability to pay. Title X Family Planning Services shall not be subject to any income reassessment fees. However, many primary care services shall require payment in part or in full prior to service being offered.

### PAYMENT

Any patient who is unable to pay for services in full at time of delivery shall complete a Payment Agreement Plan, which shall include a specified amount to be paid at regular intervals. A statement of outstanding fees shall be sent monthly to the address you provide to us. Regardless of your medical insurance coverage, our clinic relies on you to settle this account. We are very willing to work with you on payment arrangements to help you resolve a balance and avoid collection. Our clinic accepts cash, checks and debit/credit cards as forms of payment. There is a thirty-five (\$35.00) fee for all returned checks. All checks shall contain the patient's driver's license number. For account balances older than ninety (90) days, CHC may utilize an external professional collection service to secure the remaining outstanding balance. You are ultimately responsible for all clinic fees relating to your care. Please do not hesitate to contact us to discuss your account.

### DONATIONS

We are a non-profit, public health clinic. As a non-profit organization, we accept donations in support of the full range of services we provide. As required, we request you to make a donation to our agency, as all donations are tax deductible, and help us continue to serve you and other patients within our surrounding communities. Your generous donations are greatly appreciated and are applied to our general funds, unless specified otherwise. If you would like your donation restricted to a certain cause, please notify staff.

### INSURANCE

CHC accepts most medical insurance carriers, which may aid in the payment of your medical costs. Your health insurance policy is an agreement between you and your health insurance carrier. We will guide you in filing your insurance at no charge to you. Should there be any problems with an insurance claim, we request that you first direct your questions to your insurance carrier, after which our staff will be able to assist you in resolving any concerns you may have concerning your claim. However, you remain responsible for your entire balance.

### THANK YOU

We appreciate you allowing CHC to provide you the highest quality of healthcare services. We are committed to you to be the very best and providing you quality healthcare services at affordable rates. Our staff is pleased to work with you and be a lasting partner in your healthcare needs. We take great pride in our training, abilities, and dedication to all of our patients. Your input provided in the satisfaction surveys help us grow as a Center that serves your individual needs. If you should ever have any questions or concerns, we encourage you to bring those to our attention in a professional manner where we can attempt to resolve them in a timely manner.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# CENTRAL HEALTH CENTER

## Female Medical History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Chart # \_\_\_\_\_  
Reason for Visit: \_\_\_\_\_ Allergies \_\_\_\_\_  
DOB: \_\_\_\_\_ Occupation \_\_\_\_\_ Family Doctor: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Marital Status:  Single  Married  Divorced  Widowed  Separated  Living with Someone  
Are you a student:  Yes  No High Grade in School Primary Completed: \_\_\_\_\_  
Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
Please answer the following questions. This will help your physician identify possible problems:  
Age: \_\_\_\_\_ First Day of last Menstrual Period: \_\_\_\_\_ Date of last Mammogram: \_\_\_\_\_  
If you have been pregnant, please indicated how many:  
Pregnancies: \_\_\_\_\_ Abortions: \_\_\_\_\_ Living Children: \_\_\_\_\_  
Type of sexual partner:  Same Sex  Opposite Sex  Both  
# of Sexual partners Within last 3 Months: \_\_\_\_\_ # of Sexual Partners within last 12 Months: \_\_\_\_\_  
When was your last PAP test:  1-Year  2-Years  3-Years Were the results normal?  Yes  No  
How often do you get your periods? \_\_\_\_\_ Days Are your periods regular?  Yes  No  
How many days does your period last? \_\_\_\_\_ Days The blood flow is:  Light  Moderate  Heavy  
Do you have bleeding between your periods?  Yes  No Do you have any vaginal discharge?  Yes  No  
Are you sexually active?  Yes  No  
When sexually active do you use birth control?  Yes  No Birth Control Method used: \_\_\_\_\_  
Have you ever had a Sexually Transmitted Disease/STD?  Yes  No If yes, what? \_\_\_\_\_  
Level of pain during your period? (Least to Most): 0 1 2 3 4 5 6 7 8 9 10  
Pain during intercourse? (Least to Most): 0 1 2 3 4 5 6 7 8 9 10  
Do you perform self breast exams?  Yes  No  
Do you currently have any problems with your breast(s)?  Yes  No If yes, what? \_\_\_\_\_  
Have you ever been abused?  Yes  No Do you feel safe at home?  Yes  No  
Do you smoke?  Yes  No If yes, how many cigarettes per day? \_\_\_\_\_

<b>Family History:</b>	<b>Mother</b>	<b>Father</b>	<b>Siblings</b>	<b>Grandparents</b>	<b>Health Habits:</b> <i>Fill in all blanks</i>
<b>Breast Cancer</b>	Yes No	Yes No	Yes No	Yes No	Do you Exercise? Yes No
<b>Colon Cancer</b>	Yes No	Yes No	Yes No	Yes No	Do you Drink Water? Yes No
<b>Uterine Cancer</b>	Yes No	Yes No	Yes No	Yes No	Wear your seatbelt? Yes No
<b>Ovarian Cancer</b>	Yes No	Yes No	Yes No	Yes No	Drink Caffeine? Yes No # per day _____
<b>Osteoporosis</b>	Yes No	Yes No	Yes No	Yes No	Drink Alcohol? Yes No # per day _____
					Recreational Drug Use? Yes No Type _____
					IV Needle Use? Yes No

**Personal History:** *Please circle all that apply to you today*

Generally overall good Health	Unexplained weight loss or gain	Cold Symptoms	Chest Pain
Swelling in arms or legs	Abdominal Pain	Rectal Bleeding	Constipation
Headaches	Shortness of breath	Breast Pain/Lumps	Diarrhea
Blood in Urine	Urinary Burning	Vaginal Itching	Vaginal Pain
Sore or rash in Genital Area	Yellowing of Skin	Blisters	Warts
Anemia	Yellowing of eyes	Earache R L	Sore Throat
Cough	Muscle Pain	Rash	Tooth/Gum Pain
Anxiety	Depression		

To the best of my knowledge, the above history is complete and accurate. I understand the educational information give to me. I have been given an opportunity to ask questions. If I am 19 years old or younger, I have been strongly encouraged to discuss my family planning needs with my parents and I have received information on abstinence and how to resist sexual pressure. If I smoke, I have given information and understand the health risks of smoking. I have been told that if tests are taken for sexually transmitted infections (STI), reporting of positive results to public health agencies is required by law. I understand that Nebraska Health and Human Services may access my medial record to determine the quality of services provided by this agency.

CONSENT TO TREATMENT: I hereby consent to examination, consultation, testing, including HIV testing, and treatment at this clinic. If I do not want testing for HIV, I will notify personnel at CHC that I do not want to be tested for HIV.

⇒ Waiver Form Signed

(DO NOT SIGN UNTIL INSTRUCTED BY STAFF AS WITNESS)

Patient Signature: \_\_\_\_\_ Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REV 02/15/2017

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Patient Number: \_\_\_\_\_

## CENTRAL HEALTH CENTER

### HIV Waiver Form

The 2006 revised CDC recommendations for HIV Testing for Adults, Adolescents, and Pregnant Women in Health-Care Settings advocates for routine voluntary HIV screening as a normal part of medical practice, similar to screening for other treatable conditions. Screening is a basic public health tool used to identify unrecognized health conditions so treatment can be offered before symptoms develop and, for communicable diseases, so interventions can be implemented to reduce the likelihood of continued transmission.

HIV infection is consistent with all generally accepted criteria that justify screening: 1) HIV infection is a serious health disorder that can be diagnosed before symptoms develop; 2) HIV can be detected by reliable, inexpensive, and noninvasive screening tests; 3) infected patients have years of life to gain if treatment is initiated early, before symptoms develop; and 4) the costs of screening are reasonable in relationship to the anticipated benefits. Among pregnant women, screening has proven substantially more effective than risk-based testing for detecting unsuspected maternal HIV infection and preventing perinatal transmission.

However, for the following reason/s indicated I, \_\_\_\_\_, decline to be tested for HIV:

- I do not feel that I am at risk for having HIV
- I am afraid of finding out whether I may have HIV
- I am afraid of my partner finding out I was tested and/or what he/she might do to me
- I am concerned with telling my partner I was tested and losing his/her trust
- I am concerned of what my health insurance company would do if I am HIV positive
- I was recently tested and have had no new partners or risk behaviors within the past 3 months
- I want to wait until adequate time has lapsed since my last unprotected risk to be able to detect the virus

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Staff Initials: \_\_\_\_\_