NOELA COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

If you have insurance, please give ID and Insurance Card to the receptionist.

Last Name: ______________________________

First Name: ______________________________

Sex: _________ Date of Birth: ______________

Social Security Number: ___________________

Address: ________________________________

____

City: ___________________________________

State: ______ Zip Code: ___________________

Home Phone: ____________________________

Cell Phone: _____________________________

Work Phone: ____________________________

Email: __________________________________

Would you like to register for our patient portal?

Yes No (Give you access to your records online)

Language: _______________________________

Race: ___________________________________

Ethnicity: ______________________________

Marital Status: Single Married Divorce

Seperated Widowed

Are you an agricultural worker: Yes No

Are you homeless: Yes No

School-Based Health Center Patient: Yes No

Are you a veteran: Yes No

Public Housing Patient: Yes No

Consent to Call: Yes No

Consent to Text: Yes No

Authorize Medication History: Yes No

Sexual Orientation: _______________________

Gender Identity: __________________________

How did you hear about us: _________________

____

Preferred Pharmacy: _______________________

Which Location: __________________________

How many people in the household: ___________

Household Income: $_______________________

How often is this income received? Weekly

Biweekly Monthly Yearly

In case of an emergency, who can we call?

Name: _______________________

Relationship: ____________________________

Phone Number:____________________________

NOELA COMMUNITY HEALTH CENTER

CONSENT AND RELEASE

ASSIGNMENT OF BENEFITS: I authorize direct payment to NOELA Community Health Center, all of medical benefits, settlements, or judgments applicable to my treatment by NOELA CHC physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by NOELA CHC physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties' responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with collection.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FORGOING, IS THE PATIENT OR IS DULY AYTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, ACCEPTS THE TERMS THEROF, AND HAS RECEIVED A COPY THEREOF.

RELEASE OF INFORMATION: I authorized NOELA CHC and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release NOELA CHC and its physicians and clinicians from any and all responsibility relative to the release of such information.

______________________	______________________	______________________
PATIENT NAME	**DATE OF BIRTH**	**PATIENT SIGNATURE**
______________________	______________________	______________________
NAME OF AUHTORIZED AGENT, IF ANY	SIGNATURE – IF SIGNED BY AUTHORIZED AGENT	RELATIONSHIP TO PATIENT
______________________	______________________	______________________
WITNESS NAME	WITNESS SIGNATURE	DATE OF SIGNING TIME

CONSENT FOR TREATMENT

DATE__________________ TIME____________________

I, OR ____________________________ FOR ____________________________ KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT IF PHYSICISN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZED NOELA COMMUNITY HEALTH CENTER TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT NOELA COMMUNITY HEALTH CENTER.

WITNESS ________________________________ **SIGNATURE** ________________________________
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

DATE ________________________ TIME ________________________

REFUSAL OF CONSENT FOR TREATMENT

I, ____ REFUSE TO CONSENT TO ____
UPON ____

I HAVE BEEN ADVISED OF THE CONSEQUENCES AND RISKS OF SUCH REFUSAL, AND HEREBY RELEASE THE PHYSICIANS, CLINICIANS, AND NOELA COMMUNITY HEALTH CENTER FROM LIABILITY FOR INJURIES ARISING FROM SUCH REFUSAL.

WITNESS ________________________________ SIGNATURE ________________________________
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

Notice of Privacy Practices
NOELA Community Health Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of the NOELA CHC Notice of Privacy Practices.

Signature_____________________________________ Date______________

Print Patient's Name_____________________

If not signed by the patient, please indicate relationship____________________

Print Name___________________ Witness____________________________

GNOHIE Consent Form

Greater New Orleans Health Information Exchange
Health Information Notice and Patient Consent

Your health care provider belongs to and uses the Greater New Orleans Health Information Exchange (GNOHIE) to store their patient's health care information. The GNOHIE provides an easy method that allows us to share your health information electronically with our provider members and other GNOHIE partners, which include your doctors, nurses, and other care providers. This helps your doctors, nurses, and other care providers work together to provide you care.

GNOHIE protects your privacy. Only GNOHIE members and partners can see your information.

We may share:

- Your name, social security number, address, phone number, gender, ethnic group, age
- The name of the disease or health problem (diagnosis)
- Results of the lab tests, x-rays and other tests
- Medicines, including the first prescription and any refills
- Mental health information (**not** including therapy notes or minors' mental health information)
- Information regarding drug, alcohol and/or substance abuse (if any)
- HIV/AIDS tests or treatments (if any)
- Testing or treatment for STDs (sexually transmitted diseases) (if any)

Checking YES below means we can share your health information. (Your consent stays in effect until you sign a **new** form with the NO box checked.) If you **do not** give your consent, you can still get treatment. And you **will not** lose any health care benefits.

Check (✓) one:

☐ YES. My private health information may be collected, used and shared with other GNOHIE health care providers and partners.

☐ NO. My private health information **may not** be used and shared, except in an emergency.

______________________________	______________________________
Patient Name	Date
Signature of Patient or Authorized Person (Authorized signature of parent or legal guardian required if Patient is under the age of 18 or an incapacitated adult)	Name (if different from Patient)

____
Relationship to Patient

A list of all GNOHIE providers and partners is at www.gnohie.org. A printed list and the patient consent policy can be requested through your provider.

No Show Policy

We appreciate the opportunity to serve you here at NOELA Community Health Center. In order to improve quality care and provide better access to primary and preventative services, we have developed a *No Show Policy.*

If you are more than 10 minutes late for your appointment, you will be asked to reschedule for a later time and/or date. After 3 no-shows, you will not be allowed to schedule an appointment and must walk in without the guarantee of being seen. If you are going to be more than 10 minutes late for your appointment, please call the office at (504) 255-8665 and at that time you will be notified if you can still be seen.

We do understand that things come up, so if you need to reschedule or cancel an appointment, please do so at least 24 hours in advance.

If you have any questions or concerns, please feel free to call the office at (504) 255-8665.

Thank you,

NOELA Management

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

13085 Chef Menteur Hwy
New Orleans, LA 70129
Phone: (504) 255-8665 Fax: (504) 254-6447

NOELA Community Health Center Sliding Scale Discount Fee Policy

Policy

It is the policy of NOELA Community Health Center to provide essential medical services regardless of the patient's ability to pay. Discounts are offered based upon household income and size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for 12 months, after which the patient must reapply.

Discount Application Process

A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by the business office before a discount will be granted.

Services Covered and Excluded

Medical	The discount is applied to all office visits NOELA Community Health Center provides.
Pharmacy	Samples are provided, when available, without charge.
Labs	N/A

NOELA Community Health Center
Discounted/Sliding Fee Application

It is the policy of NOELA Community Health Center, to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members or your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. Please inquire at the front desk if you have questions.

Number of related persons living in your household: _______

Total household income (complete one column):

Household Members	Household Income (complete one column)		
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children under age 18			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans' payments, net business or self-employment, alimony, child support, military, unemployment, and public aid.

I certify that the family size and income information shown above is correct. Copies of tax return, pay stubs, and other information verifying income may be required before a discount is approved.

______________________________ ______________________________

Name (Print) Signature / Date

Office Use Only

Patient Name: ______________________ Discount: ______________________

Date of Service: ______________________ Approved by: ______________________

Family Size	Income Level 1	Income Level 2	Income Level 3	Income Level 4	Income Level 5	Income Level 6
1	$0 - **$11,880**	$11,881 – **$14,850**	$14,851 - **$17,820**	$17,821 - **$20,790**	$20,791 - **$23,759**	**$23,760+**
2	$0 - **$16,020**	$16,021 – **$20,025**	$20,026 - **$24,030**	$24,031 - **$28,035**	$28,036 - **$32,039**	**$32,040+**
3	$0 - **$20,160**	$20,161 – **$25,200**	$25,201 - **$30,240**	$30,241 - **$35,280**	$35,281 - **$40,319**	**$40,320+**
4	$0 - **$24,300**	$24,301 – **$30,375**	$30,376 - **$36,450**	$36,451 - **$42,525**	$42,526 - **$48,599**	**$48,600+**
5	$0 - **$28,440**	$28,411 – **$35,550**	$35,551 - **$42,660**	$42,661 - **$49,770**	$49,771 - **$56,879**	**$56,880+**
6	$0 - **$32,580**	$32,581 – **$40,725**	$40,726 - **$48,870**	$48,871 - **$57,015**	$57,016 - **$65,159**	**$65,160+**
7	$0 - **$36,730**	$36,731 – **$45,913**	$45,914 - **$55,059**	$55,096 - **$64,278**	$64,279 - **$73,459**	**$73,460+**
8	$0 - **$40,890**	$40,891 – **$51,113**	$51,114 - **$61,335**	$61,336 - **$71,558**	$71,559 - **$81,779**	**$81,780+**

For families/households with more than 8 persons, ADD $4,160 for each additional person.

FAMILY SIZE INCLUDES = Applicant + Spouse/Significant Other + Legal Tax Dependents
FAMILY UNIT INCOME INCLUDES = All Jobs, Child Support, Disability/Soc. Sec. Benefits

You MUST inform the health center immediately of any changes in family income or size. You may request to reapply at any time if your income changes

To Apply, One of the Following MUST be Provided:

- ☐ Most recent Income Tax Return OR a signed 4506T IRS Form (if no taxes were filed)
- ☐ Most recent Tax Return + Schedule C or CEZ Tax Form (if self-employed)
- ☐ Most recent Consecutive Pay Stubs (Paid Weekly = 4 Paystubs, Bi-Weekly = 3 Paystubs)
- ☐ If paid in Cash, the Employment Income Verification Form MUST be completed by Employer
- ☐ Benefit Checks/Statement (Unemployment, Disability, Social Security, Alimony, Child Support)
- ☐ Income Verification (SNAP, TANF, WIC, Energy Assistance….) from Social Services OR signed Authorization to Release Income Verification
- ☐ If NO Income, a letter of Support from the Sponsor Providing Basic Needs (Food, Shelter, Clothing, Financial Support)
- ☐ A Signed Letter Identifying Legal Dependants by Full Name and Date of Birth

Required Documentation need to be submitted within 30 days of service date.

______________________________ ______________________________

Signature of Applicant Date

Initial Health History Questionnaire

Name: ______________________________ **DOB:** ____________________

Allergies

Drug/Food	Reaction

Current Medications

Medication	Frequency of Dose

Current Medical Problems/Conditions

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

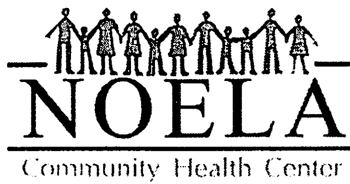
Surgeries

Date	Description	Location

Family History

Does anyone in your family currently have or have had any medical problems or conditions?

Condition	Relation to You	Maternal/Paternal



Social History

Smoking: Yes / No Years smoked: _____ Number of cigarettes per day: _____

Alcohol: Yes / No Number of drinks per day/week: _____

Illicit Drugs: Yes / No

Diet: Regular / Vegetarian / Vegan / Gluten Free / Carbs / Cardiac / Diabetic / Specific

Caffeine Intake (Coffee, Soft Drinks, Tea, etc.): None / Occasional / Moderate / Heavy

Exercise Level: None / Occasional / Moderate / Heavy

General Stress Level: Low / Moderate / High

Marital status: Single / Married / Divorced / Separated / Widowed

Assigned sex at birth: Male / Female

Sexual Orientation: _______________

Gender Identity: _______________

Employed: Yes / No

Occupation: ____________________________

Able to care for self: Yes / No

Living alone or with others: Alone / With others

Hard of hearing or deaf in one or both ears: Yes / No

Legally blind in one or both eyes: Yes / No

Hand dominance: Left / Right

Smoke alarms in the home: Yes / No

Anyone smoking inside/outside the home: Yes / no

Guns present in the home: Yes / No

Seat belts used routinely: Yes / No

Sunscreen used routinely: Yes / No

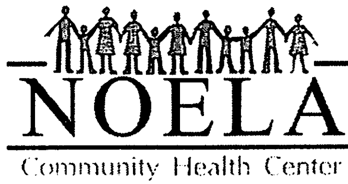
Sexually Active: Yes / No

History of STIs/STDs: Yes / No

Flu Vaccine: ______________

Tetanus: ______________

Colonoscopy: ______________



Gynecological History

Age at 1st menstrual period: ______

Date of last menstrual period: __________

Duration of the flow: ______ Flow: Light / Moderate / Heavy

Frequency of menstrual cycle (1st day of one to the 1st day of the next): ______

Monthly menstrual cycle: Yes / No

Age at first child: ______ On birth control at conception: Yes / No

Currently on birth control: Yes / No If yes, what type: __________________________

Interested in birth control: Yes / No

Birth plan: Yes / No

Date of last pap smear: _______________ Was pap: Normal / Abnormal

Any previous abnormal pap: Yes / No

Performs monthly self-breast exam: Yes / no

Date of last mammogram: _______________

Age at menopause: ______

Post-menopausal bleeding: Yes / No

Sexual problems: Yes / No

Sexually active: Yes / No

History of STIs/STDs: Yes / No

Date of last colposcopy: _______________

Hormone replacement therapy: Yes / No

Obstetrical History

Total Pregnancies: ______

Full Term: ______

Premature: ______

Multiple Births: ______

Induced Abortions: ______

Miscarriages: ______

Ectopic: ______

Living Children: ______

Vaginal Deliveries: ______

Cesarean Deliveries: ______