

**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: _____

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

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

Mother / Guardian Information

Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone Number: _____

Father / Guardian Information

Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone Number: _____

In case of an emergency, who can we call?

Name: _____

Relationship: _____

Phone Number: _____

NOELA COMMUNITY HEALTH CENTER

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

Delegation of Consenting Authority

Date: _____

Account: _____

I, _____, authorize the following individuals to consent for medical treatment including, but not limited to, vaccination(s) by physician(s) for my child(ren).

Child's Name (please print)	Date of Birth

The consent given by the authorized designee shall be valid and binding as would the consent given by the parent(s) and the physician(s) can rely on this authorization and accept any consent given by authorized designee until such time as physician receives written notice that authorization is revoked.

Authorized Designee

Name	Relationship to Patient

Parent / Guardian Consent

Signature	Relationship to Patient	Date

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 AUTHORIZED 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

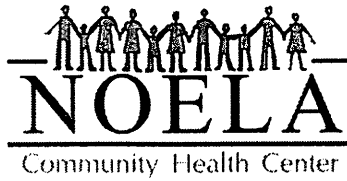
Date

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: _____

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	\$28,441 - \$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 Dependents by Full Name and Date of Birth

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

Signature of Applicant _____

_____ Date



NOELA Community Health Center-Pediatrics
13085 Chef Menteur Hwy, New Orleans, LA 70129
Phone (504) 255-8665 Fax (504) 254-6447

Initial History Questionnaire

Child's Name: _____ DOB: _____ Chart: _____

Household (Please list those living in the child's home.)

Name	Relationship to Child	Date of Birth	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

If mother and father are not living together, or if the child does not live with the parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent(s) not living in the home? _____

Birth History

Birth Weight: _____

Delivery: VAGINAL / CESAREAN If cesarean, please explain _____

Was the baby born at term? YES/ NO If no, please explain. _____

If the baby was born early, how many weeks early? _____ Did mother have prenatal care? YES / NO

Did the baby have any complications right after birth? YES / NO If yes, please explain. _____

Did mother have any illnesses or complications with her pregnancy? YES / NO If yes, please explain. _____

During pregnancy, did mother: Smoke: YES/ NO Drink Alcohol: YES / NO

During pregnancy, did mother use medications or street drugs? YES / NO If yes, what and when: _____

Was initial feeding: BOTTLE or BREAST?

Did the baby go home with mother from the hospital? YES / NO If no, please explain: _____

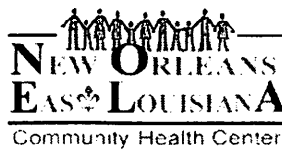


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Child's Name: _____ DOB: _____ Chart: _____

Child's History

GENERAL			
Does your child have any serious illnesses or medical conditions?	YES	NO	
Has your child has any serious injuries or accidents?	YES	NO	
Has your child had any surgeries?	YES	NO	
Has your child been hospitalized?	YES	NO	
Is your child allergic to any medications or food?	YES	NO	
DEVELOPMENT	YES	NO	
Does your child have physical development problems?	YES	NO	
Does your child have mental or emotional development problems?	YES	NO	
Does your child have problems with their attention span?	YES	NO	
IF YOUR CHILD IS IN SCHOOL	YES	NO	
Does your child have behavioral problems at school?	YES	NO	
Has he/she repeated a grade in school?	YES	NO	
Does your child have academic problems in school?	YES	NO	
Is he/she in special or resource classes?	YES	NO	
PAST HISTORY (Does your child have, or has he/she ever had?)	YES	NO	
Chicken pox, measles, mumps, or rubella	YES	NO	
Frequent ear infections	YES	NO	
Nasal allergies	YES	NO	
Problems with eye or vision (wears glasses or contacts)	YES	NO	
Asthma, bronchitis, bronchiolitis, or pneumonia	YES	NO	
Any heart problems or heart murmur	YES	NO	
Anemia or bleeding problems	YES	NO	
Blood transfusion	YES	NO	
Frequent abdominal pain	YES	NO	
Constipation requiring doctor visits	YES	NO	
Bladder or kidney infections	YES	NO	
Bed-wetting (after 5 years old)	YES	NO	
(FOR GIRLS) Has she started her menstrual periods?	YES	NO	
(FOR GIRLS) Are there problems with her periods?	YES	NO	
Any chronic or recurrent skin problems (acne, eczema, etc.)	YES	NO	
Frequent headaches	YES	NO	
Convulsions or other neurologic problems	YES	NO	
Diabetes	YES	NO	
Thyroid or other endocrine problems	YES	NO	
Delayed speech or speech problems	YES	NO	
Eating problems	YES	NO	
Dental disease or caries	YES	NO	
Any other significant problems?	YES	NO	



Community Health Center
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Child's Name: _____ **DOB:** _____ **Chart:** _____

Family History (Has any family members had the following?)

Deafness	YES	NO	
Nasal Allergies	YES	NO	
Asthma	YES	NO	
Cancer	YES	NO	
Tuberculosis	YES	NO	
Heart Disease (over the age of 50)	YES	NO	
High blood pressure (over the age of 50)	YES	NO	
High cholesterol	YES	NO	
Anemia	YES	NO	
Sickle cell	YES	NO	
Bleeding disorder	YES	NO	
Liver disease	YES	NO	
Kidney disease	YES	NO	
Diabetes (before the age of 50)	YES	NO	
Bed-wetting (after 10 yrs old)	YES	NO	
Epilepsy or convulsions	YES	NO	
Alcohol abuse	YES	NO	
Mental illness	YES	NO	
Mental retardation	YES	NO	
Immune problems HIV or AIDS	YES	NO	
Glaucoma or blindness	YES	NO	
Additional family history?	YES	NO	