COMMUNITY HEALTH INTERVENTIONS, INC. – SPECIALITY CLINIC

Patient Registration Form

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ❑ Voice ❑ Text		If Voice, Please Select Preferred Number: ❑ Home ❑ Cell ❑ Work	
Family Physician:	Date of Birth:	Sex: ❑ Male ❑ Female ❑ Other	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Email Address:	Can we leave a message regarding your medical care & test results? ❑ Yes ❑ No
Race (please select): ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Hispanic ❑ Black or African American ❑ Native Hawaiian or Pacific Islander ❑ Other ❑ Decline	**Ethnicity (please select one):** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name & Policy Number	Ins. Co. Name & Policy Number
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Community Health Intervention, Inc. payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PHMG all money to which I am entitled for medical expenses related to the services performed from time to time by CHI, Inc. but not to exceed my indebtedness to CHI, Inc. I authorize CHI, Inc. to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $15.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from CHI, Inc. by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to CHI, Inc. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Community Health Interventions, Inc. Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: _____ **Date:** _____

Printed Name of Responsible Party: _____ **Date:** _____