



## Patient Intake Form

PATIENT INFORMATION

Name: \_\_\_\_\_ Previous Name/Alias: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex (circle): Male, Female, Unknown

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Street Address (if different): \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone: ( )- \_\_\_\_\_ [ ] Home [ ] Work [ ] Cell      **Who will you be seeing today? (Circle)**  
 Phone: ( )- \_\_\_\_\_ [ ] Home [ ] Work [ ] Cell      Dr. Campbell    Dr. Scarborough  
 Phone: ( )- \_\_\_\_\_ [ ] Home [ ] Work [ ] Cell

\*\*\*Can we leave messages for you at your home? (circle one) YES NO

In case of an emergency, who can we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Are you Employed? (circle one) YES NO

Employer Name: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 Employer Phone Number: \_\_\_\_\_

\*\*How did you hear about us? \_\_\_\_\_

**Please provide your insurance card or cards and drivers license (or identification card) information. If an updated insurance card has been provided, please complete the Guarantor (Responsible Party) information below only. If no card provided, please complete all selections that may apply.**

GUARANTOR or RESPONSIBLE PARTY (if not same as above)

[ ] Same as Patient

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: ( )- \_\_\_\_\_ [ ] Home [ ] Work [ ] Cell

Phone: ( )- \_\_\_\_\_ [ ] Home [ ] Work [ ] Cell

PRIMARY INSURANCE

Same as Patient     Same as Guarantor or Responsible Party     Other

Insured Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Ins. Company: \_\_\_\_\_ Insured ID: \_\_\_\_\_ Copayment \$ \_\_\_\_\_

Employer: \_\_\_\_\_ Policy Group: \_\_\_\_\_ Group # \_\_\_\_\_

SECONDARY INSURANCE

Same as Patient     Same as Guarantor or Responsible Party     Other

Insured Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Ins. Company: \_\_\_\_\_ Insured ID: \_\_\_\_\_ Copayment \$ \_\_\_\_\_

Employer: \_\_\_\_\_ Policy Group: \_\_\_\_\_ Group # \_\_\_\_\_

**Self-Pay Patients:** I understand that it is my responsibility to receive services such as labs, radiology, x-rays, and other procedures from facilities recommended by Christ Community Health Services. I also understand that I am personally responsible for the amount of any services rendered through referrals and other appointment visits outside of Christ Community. \_\_\_\_\_

**Patient or Authorized Signature**

**Insurance/Self-Pay Patients:** I hereby authorize and consent to examinations, treatments, and release of medical information to other physicians, insurance companies, claim representatives, and adjusters necessary to process claims and assign to the physician payment for medical services. I understand it is my responsibility to see that pre-certifications and authorizations are completed for me and my dependents. \_\_\_\_\_

**Patient or Authorized Signature**

**Insurance Patients:** I understand I am personally responsible for any amount not covered by insurance for services rendered to myself and my dependents, whether this is due to deductibles, non-covered services or out-of-network situations. \_\_\_\_\_

**Patient or Authorized Signature**

**Insurance Patient:** I understand it is my responsibility to know which facilities for radiology, labs, and other procedures are in-network with my insurance. \_\_\_\_\_

**Patient or Authorized Signature**

**Medicare Patients:** I also authorize any holder of medical or other information about me or my dependents to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original and request payments of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. \_\_\_\_\_

**Patient or Authorized Signature**

**I have read the above statements, have reviewed the above information for correctness, and have made any and all changes necessary.** \_\_\_\_\_

**Patient or Authorized Signature**

**Date**



# Christ Community

HEALTH SERVICES, AUGUSTA, GEORGIA

## Privacy Policy Acknowledgment (HIPAA)

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

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

I have had the opportunity to review the Notice of Privacy practices for PHI before signing this consent. I give permission to Christ Community Health Services to disclose information about myself (or another person for whom I have authority to sign) that is protected under federal law for the purposes of treatment, payment, and healthcare operations. I also authorize Christ Community Health Services to communicate with the following individuals about my condition or treatment. **In accordance with federal laws, I understand that medical information may be withheld from individuals, including my family members, unless I list them by name below.**

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Phone Number \_\_\_\_\_ [ ] Home [ ] Work [ ] Cell

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Phone Number \_\_\_\_\_ [ ] Home [ ] Work [ ] Cell

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Phone Number \_\_\_\_\_ [ ] Home [ ] Work [ ] Cell

\*Can we leave messages for you at your home? (Circle One) **YES NO**

\*If we cannot reach you at your home, who else can we leave messages with? \_\_\_\_\_

\_\_\_\_\_

\*\*Print the telephone number where you would like to receive calls and messages about your appointments, labs, and x-ray results, and other health care information if other than your home phone number: \_\_\_\_\_

\*\*I am fully aware that my medical information will be transmitted by electronic transmission, fax , internet, or email.

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



# Christ Community

HEALTH SERVICES, AUGUSTA, GEORGIA

## FINANCIAL VERIFICATION

Thank you for choosing Christ Community as your medical provider. In order to place you on our sliding scale fee program, we must verify your household financial situation. CCHSA defines "household" as any group of people financially dependent upon one another. Thank you for taking the time to fill out this form.

**Patient Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Please list all people living in your household and their relation to you

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**Please indicate below all types of financial support being received by anyone in the household and amount from each source of support. Please indicate if financial support is received on a weekly, biweekly, or monthly basis. Proof of income must accompany this form in order to verify stated financial support**

- |                    |          |                                       |          |
|--------------------|----------|---------------------------------------|----------|
| 1. Paycheck        | \$ _____ | 5. Alimony                            | \$ _____ |
| 2. Unemployment    | \$ _____ | 6. Worker's Compensation              | \$ _____ |
| 3. Social Security | \$ _____ | 7. TANF                               | \$ _____ |
| 4. Disability      | \$ _____ | 8. Housing Vouchers                   | \$ _____ |
| 5. Foodstamps      | \$ _____ | 9. Student Loans                      | \$ _____ |
| 4. Child Support   | \$ _____ | 10. Other                             | \$ _____ |
|                    |          | 11. Assistance from Friends or Family | \$ _____ |

I certify under penalty of law that the above information is accurate and complete. I agree to pay my copay at each appointment before services are rendered. I understand that I will not receive services unless my copay has been paid in full. I understand that if any other financial support is disclosed to CCHSA, CCHSA reserves the right to adjust my copay accordingly. I understand that if I present fraudulent financial information, CCHSA reserves the right to discharge me as a patient from their practice. I understand that CCHSA will not release any of my financial information to any other organization unless deemed necessary for further treatment and care but not without my prior knowledge and approval.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**



# Christ Community

HEALTH SERVICES, AUGUSTA, GEORGIA

## 2011 Patient and Financial Policies

With the beginning of the New Year, we will be adjusting our patient and financial policies. We are adjusting our policies in accordance the demands and needs we experienced in 2009 and to provide better overall quality care to our patients. **Please review the following policies and sign below.** Please address all questions to the Front Office or Front Office Manager. Thank you and Happy New Year!

### I. Increase in Sliding Fee Scale Payments

Our payment plans are now \$25, \$35, \$45, \$55 and 50%.

### II. Fee for Nursing Visits

All nursing visits will now cost \$5. This payment will assist in covering the cost of materials and procedures necessary during nursing visits.

### III. No Show Policy

Beginning in January 2010, our new No Show Policy will be effective for all new and established patients. Our No Show Policy will assist us in providing better continuity of care to each of our patients and will create more ease in scheduling appointments with a decreased wait time. A No Show is considered any appointment that is not cancelled or rescheduled before the regularly scheduled appointment time.

- First No Show Appointment- The patient will be called to be informed of their missed appointment and informed of our No Show Policy.
- Second No Show Appointment- The patient will receive a letter in the mail informing him/her of the second missed appointment.
- Third No Show Appointment- The patient's third missed appointment will be brought to the attention of his/her physician and will be reviewed by our Patient Review Board. The patient will receive a letter in the mail informing him/her that he/she is no longer eligible to schedule another appointment for one year.

I have read the above information, understand and consent to abide by the new policies. I understand that if I do not have payment at time of service, my appointment will be rescheduled. I understand the No Show Policy and agree to the consequences that will follow if I miss an appointment without rescheduling or canceling.

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Signature

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Date

