West Caldwell Health Council, Inc.

Collettsville Medical Center
4330 Collettsville Rd
Collettsville, NC 28611
Tel: (828) 754-2409 Fax: (828) 754-2418

Happy Valley Medical Center
1345 NC Highway 268
Lenoir NC 28645
Tel: (828) 754-6850 Fax: (828) 757-3214

Patient Information:

Name (Last, First, Middle): _____

Preferred Name: _____

Physical/Street Address: _____

Mailing Address if Different: _____

City/State/Zip: _____

Gender:
____ Male
____ Female
____Unidentified

Gender Identity:
____Male ____Transman
____Female ____Transwoman
Other (Specify):_____

Sexual Orientation:
____Straight ____Bisexual
____Gay/Lesbian ____ Unknown
Other (Specify):_____

Social Security Number: _____ Date of Birth: _____

Marital Status: ____Single ____Married ____Separated ____Widowed ____Divorced

Home Phone: _____ Work Phone: _____ Cell/Alt Phone: _____
Note: Phone numbers will be used for reminder calls.

Email Address: _____
Note: This email address will be used for patient satisfaction surveys and patient portal updates.

Additional Information:

Race (Choose One): ____ American Indian/Alaska Native ____ Asian ____ Black/African American
____ Native Hawaiian/Other Pacific Islander ____ White ____ Two or more Races

Ethnicity (Choose One): ____Hispanic ____ Non-Hispanic

Preferred Language: ____English ____Spanish Other (Specify):_____

OR I choose not to report Demographic Information. _____(Initial here)

Insurance Information:

Do you have Medical Insurance? (Circle One) YES NO
Primary Insurance Carrier:_____

Do you have Secondary Medical Insurance? (Circle One) YES NO
Secondary Insurance Carrier: _____

Are you covered by a Drug Plan? (Circle One) YES NO

West Caldwell Health Council Inc. offers a Discounted Services Program to low income individuals who qualify.
Would you like information about this program? (Circle One) YES NO

West Caldwell Health Council Inc. offers a Medication Assistance Program to low income individuals who qualify.
Would you like information about this program? (Circle One) YES NO

_____
Signature of Patient, Parent or Guardian, or Health Care Power of Attorney **Date**

West Caldwell Health Council, Inc.

Collettsville Medical Center
PO Box 9
Collettsville, NC 28611
828-754-2409

Happy Valley Medical Center
PO Box 319
Patterson, NC 28661
828-754-6850

MEDICAL & FAMILY HISTORY

Full Name:	Date of Birth:

PAST MEDICAL HISTORY

	Anxiety		Diarrhea		High Blood Pressure		Stroke
	Appetite changes		Dizziness/ Fainting		Kidney Stones		Swallowing Difficulty
	Asthma		Eating Disorders		Lactose Intolerance		Swelling of joints
	Breathing Difficulty		Ears (ringing)		Mental Illness		Tremors
	Bleed / Bruise Easily		Fatigue (chronic)		Migraine Headaches		Thyroid Disorder
	Cancer (describe)		Gout		Muscle Weakness		Ulcers - stomach
	Chest Pain		Heartburn		Nausea/ Vomiting		Urinary problems (desc)
	Constipation		Heart Murmur		Numbness hand /feet		Varicose veins
	Cough - chronic		Hemorrhoids		Pain (describe)		Visual problems
	Depression		Hernia		Seizures		Weight change
	Diabetes		Hepatitis		Sleep Apnea		Wounds (legs heal poor)

DESCRIPTION / COMMENTS:

Blood transfusion in past	Dental issues	Implantable Devices	Moles that have changed
Are you sexually active	Birth control method	Number of pregnancies	Date last period

HOSPITALIZATIONS	SURGICAL PROCEDURES

LIFESTYLE HABITS

Substance Use	Alcohol (started when/how often)	Tobacco Use(began / how often)
Caffeine Use	Diet: Regular, Low Salt, Low Fat, Diabetic	Exercise

MEDICATIONS / ALLERGIES – *use back of sheet if more space is needed*

Name	Dose/ Strength	Name	Dose / Strength

Allergies (medication/ food/ latex)	Reactions

FAMILY HISTORY

	Parent	Grand parent	Sibling		Parent	Grand parent	Sibling
Asthma (Z82.5)				High Blood Pressure (Z84.89)			
Cancer (describe) (Z80.?)				Kidney Disease (Z84.1)			
Diabetes (Z83.3)				Mental Illness (Z81.8)			
Glaucoma (Z83.511)				Stroke (Z82.3)			
Heart Disease (Z82.49)				Substance Abuse (Z81.?)			

Patient / Guardian Signature: _____Date:_____

Patient Name: _____ Date of Birth: _____

List the Name, Address and Phone Number (if known) of all medical providers, urgent care facilities, Emergency Room/Emergency Department and Hospitals whereby you have received medical care in the last two years.

1.

2.

3.

4.

5.

6.

*Use back if additional space is needed**

Name: _____Date of Birth: _____

We operate as Federally Qualified Community Health Centers and are required to keep certain statistical information for annual Uniform Data System (UDS) reporting. Please help us keep our database current by providing the following:

Family Size – How many people live in your Household? _____

Family Income – Annual (circle one):

Less than $10,000	$40,001 to $50,000
$10,001 to $20,000	$50,001 to $60,000
$20,001 to $30,000	$60,001 to $70,000
$30,001 to $40,000	More than $70,001

Third Party Insurance: What type of health insurance do you have? Circle below:

None Medicare Medicaid Private Insurance

Children Living – How many children do you have (born to you)? _____

Limited English Proficiency (LEP): Is English your primary language? Circle one: Yes No

Migrant Status– If yes, circle one: Migrant Seasonal

Homeless Status - If yes, circle one: Homeless Shelter Transitional
Doubling Up Street Other

Veteran Status - Have you ever served in the US Military? Circle one: Yes No

Patient Questionnaire

In our effort to better serve you and to comply with the privacy regulations mandated by the Governing laws, both Federal and State, we are asking you to take time to complete the following questionnaire and return to us to have for your records.

Sharing of Protected Health Information - I consent to disclosure of the following protected health information about me to the following person(s) involved in my care or payment for my care. If none, please write "None".

Name: _____ **Date of Birth:** _____

Address: _____ **Best Phone Number:** _____

Check all that apply:

Contact Person Name and Relationship	Phone Number	Information necessary to call in/pick up prescriptions or medical equipment	Information necessary to schedule appointments for me, including payment info	All of my medical information - including lab and test results

Pharmacies/Drug Stores/Medical Supply Companies where you want your prescriptions called, faxed or electronically

sent: _____

_____

Signature of Patient, Parent or Guardian, or Health Care Power of Attorney **Date**

Revised 11-1-2021

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Fax: (828) 757-3214

STATEMENT TO PERMIT TREATMENT, OPERATION AND PAYMENT OF INSURANCE AND RELEASE OF MEDICAL INFORMATION

By my signature below, I hereby consent for treatment.

_____

Type or Print Name of Patient

_____

Signature of Patient, Parent or Guardian, or Health Care Power of Attorney **Date**

By my signature, I indicate that I have read the Financial Policy, understand its content and agree to its provisions. I hereby give the West Caldwell Health Council, Inc. clinics a lifetime authorization to submit insurance claims of any kind on my behalf and to receive payment for services rendered at these clinics and all or any of its assignees, associates, or colleagues.

Also by my signature, I authorize the release of any and all protected health information needed to file any insurance claims on a lifetime basis.

_____

Type or Print Name of Patient

_____

Signature of Patient, Parent or Guardian, or Health Care Power of Attorney **Date**

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TOBACCO POLICY

The use of tobacco products of any kind or description is prohibited on any property owned, occupied, or leased by West Caldwell Health Council, Inc. This includes, but is not limited to:

- Buildings
- Parking Lots
- Motor Vehicles
- Sidewalks

Tobacco products include, but are not limited to:

- Cigarettes
- Cigars
- Smokeless Tobacco Products (Chewing Tobacco, Snuff, Dip)
- Pipes
- eCigarettes and Vaporizers (Vapes)

Anyone found using tobacco products of any kind on the property will be dismissed as a patient.

Further, anyone accompanying a patient, who is found using tobacco products of any kind on the property, will result in the dismissal of the patient.

Revised 05/2016

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Appointment "No-Show" Policy

When you schedule an appointment with one of our providers that time is reserved exclusively for you to discuss and review your medical concerns. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. Providing our office with adequate notice will allow us to offer that appointment time to another patient who needs to see the provider.

Failure to notify us may result in "no-show" and/or late cancellation fees.These fees must be paid prior to being seen at your next visit. You are responsible for any "no-show" fees you are charged; your insurance company will not be billed.

A "no- show" is an appointment that is:

- missed without notice
- canceled with less than 24 hours notice
- rescheduled due to arriving 15 minutes or more beyond the scheduled appointment time
- rescheduled due to failure to bring medications

If a patient has continuous "no-show" visits over a defined period of time, WCHC reserves the right to dismiss that patient from our clinics.

Consecutive No-Shows: After the third consecutive "no-show" appointment, the patient may be dismissed as a patient

Non- Consecutive No-Shows: After the fifth non-consecutive "no-show" within one year, the patient may be dismissed as a patient

Revised 07/2017

FINANCIAL POLICY

SUMMARY OF COLLECTION POLICIES

1. Full payment for services is expected at the time of the visit unless insurance will cover the charges for the day.

2. If the service is covered by insurance, the deductible and coinsurance payment is expected at the time of the visit. If an insurance payment is not received 120 days after insurance is filed, the patient will be held responsible for the charges.

3. Patients with insurance are responsible for services not covered by their insurance.

4. The practice will file up to two insurance claims on behalf of the patient. Patients with more than two insurance companies will receive the necessary documentation to file their claims or may pay $25.00 per additional claim to have more than two claims filed.

5. Patients are given the option of paying for services with cash, by check, or with a credit/debit card.

6. There will be a $25.00 fee for processing Non-Sufficient Funds (NSF) checks. Additional checks will not be accepted until the NSF check and related fees have been paid.

7. Patients with outstanding balances greater than $25.01 will be billed monthly. Patients with outstanding balances of $25.00 or less will be billed quarterly. Payment is due upon receipt of the patient statement.

8. Patients who have difficulty paying off their account in full upon receipt of the billing statement must contact the practice to make payment arrangements.

9. Patients who make no effort to pay off their outstanding balances on a timely basis, and do not contact the practice to make payment arrangements, will be subject to a progressive collection system.

10. After four billing cycles, patients who do not make an attempt to clear their accounts or make payment arrangements, may be subject to a collection agency and/or court action, and ultimately may be denied services from the practice.

If you are having trouble reading or understanding these policies, please ask the receptionist for assistance.

Revised 08/2020

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ACKNOWLEDGEMENT OF DISCLOSURES

Instructions: Initial each line, sign and date at the bottom.

_____ By my signature, I indicate that I have received a copy of and read the Tobacco Policy (Rev. 05/2016) and understand its content.

_____ By my signature, I indicate that I have received a copy of and read the Financial Policy, Summary of Collection Policies (Rev. 08/2020), and understand its content.

_____ By my signature, I indicate that I have received a copy of and read the Appointment "No Show" Policy (Rev. 07/2017) and understand its content.

_____ By my signature, I indicate that I have received a copy of the Notice which describes "How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information", effective 09/15/2013.

_____

Type or Print Name of Patient

_____

Signature of Patient, Parent or Guardian, or Health Care Power of Attorney **Date**