Charlotte Community Health Clinic
New Patient Application

Thank you for choosing Charlotte Community Health Clinic as your health care provider. Please complete this application and submit your completed application along with all required documents shown below. We will call you to schedule your first appointment once we process your application. If you have questions, go to our website at www.CharlotteCommunityHealth.org or call the clinic at (704) 316-6561.

All new patients:

Completed New Patient Application

Copy of identification for all members of the household who are applying for services

- Adults can use a driver's license, passport, or permanent resident card
- Children can use a school ID, social security card, or birth certificate

Patients with insurance:

Copy of insurance card

Patients without insurance, or patients with insurance who are applying for Sliding Scale discounts:

Proof of Income (ONE of the following)

If currently working:

- Most recent Federal Income Tax Return
- Most recent W2 forms
- Last 30 days of pay stubs
- A letter from employer on letterhead stating income (must include contact name and phone number)
- Last 30 days of bank statements showing direct deposits

If not currently working:

- Unemployment verification
- SSI or SSDI benefit letter
- Alimony or child support agreement
- If homeless, a letter from the shelter where you are getting services
- If supported by a family member or friend, a letter of support from that person

Return all required forms and documents:

Bring printed copies to either clinic location:

8401 Medical Plaza Dr
Suite 300
Charlotte NC 28262

5301 Wilkinson Blvd
Charlotte NC, 28208

Email electronic copies to financial.docs@cchc-clt.org

Icons by LAFS at thenounproject.com and Freepik at Flaticon.com. Updated 2/14/20.

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
MRN: _____

Sliding Scale Application

If you DO NOT wish to apply for the sliding scale discount program:

Name: _____ Date of Birth: _____

☐ I have been given the opportunity to apply for the CCHC discount services sliding fee schedule, and I DO NOT WISH TO APPLY FOR THE CCHC DISCOUNT SERVICES SLIDING FEE PROGRAM AT THIS TIME.

Patient/Guardian Signature: _____ Date: _____

If you DO wish to apply for the sliding scale discount program:

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical, behavioral health and dental needs. **This form will not be used to withhold or deny services to you.**

1. Is any other family member applying for a discount? ☐ Yes ☐ No
   If yes, please indicate in final column below
2. Are you covered under Medicaid, Medicare or any other insurance? ☐ Yes ☐ No
3. Would you like assistance applying or re-applying for Medicaid? ☐ Yes ☐ No
4. Are you unemployed? ☐ Yes ☐ No
5. Are you too sick to work or are you disabled? ☐ Yes ☐ No

TO BE COMPLETED BY PATIENT/GUARDIAN: Please include yourself, your spouse /partner, children and everyone else living in the home. See attached list for acceptable forms for proof of income and household members.

Name	Relation in Family	Date of Birth	Income	Frequency	Proof of Income	Health Insurance plan(s)	Annual Deductible	Applying for Assistance?
Ex: John Doe	self	5/16/46	$346	weekly	Tax Form	Medicare	none	yes

I have attached proof of income for the amounts listed above. ☐ Yes ☐ No

I have provided identification for household members listed above. ☐ Yes ☐ No

I understand that the information I provide on this form is subject to verification by Charlotte Community Health Clinic. I certify that the above information is true and correct to the best of my knowledge and that I understand & agree that providing false information can result in me being denied ability to apply for the program; furthermore I agree to adhere to all terms and conditions of the Sliding Fee Discount Program. I will report any changes of the above information to CCHC. **I also understand that I must supply proof of income before my next visit, or I will have to pay the full price with no discount.**

_____ _____ _____

Patient/Guardian Signature | Printed Name | Date

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
MRN: _____

Patient Registration Form

Patient Information

Full Legal Name: _____ Referred By: _____
If patient is a minor, Parent/Legal Guardian Name: _____
Date of birth: _____ Social Security/W7 #: _____-____-_____
Street Address or PO Box: _____
City: _____ State: _____ Zip Code: _____ County: _____
Email: _____ Home Phone: _____ Work Phone: _____
Emergency Contact: _____ Telephone: _____ Relationship: _____
Which services are you applying for? ☐ Medical ☐ Dental ☐ Behavioral Health

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Other: _____

Country of Origin: _____
Do you need an interpreter (language or American Sign)?
- ☐ Yes
- ☐ No

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Employment Status:
- ☐ Working full time
- ☐ Working part time
- ☐ Unemployed

Student Status:
- ☐ Full time student
- ☐ Part time student
- ☐ Not a student

Are you a farmworker?
- ☐ Yes – migrant farmworker
- ☐ Yes – seasonal farmworker
- ☐ No

Are you a veteran?
- ☐ Yes
- ☐ No

Ethnicity:
- ☐ Hispanic or Latino/a
- ☐ Non-Hispanic or Latino/a

Race:
- ☐ American Indian/Native American
- ☐ Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Other: _____

Gender:
- ☐ Man
- ☐ Woman
- ☐ Transgender Man (F to M)
- ☐ Transgender Woman (M to F)
- ☐ Other: _____

Sexual Orientation:
- ☐ Straight (not lesbian or gay)
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Other: _____
- ☐ Don't know/Questioning
- ☐ Prefer not to answer

Number of people in household:
Adults: _____
Children: _____

Where do you live?
- ☐ Rent or Own Home/Apartment
- ☐ Public Housing
- ☐ Shelter
- ☐ Street/Car
- ☐ Transitional or living place to place
- ☐ Doubling up or staying with family/friends
- ☐ Other: _____

Household Income Range:
- ☐ Less than $11,500
- ☐ $11,501 – 15,000
- ☐ $15,001 – 20,000
- ☐ $20,001 – 30,000
- ☐ $30,001 – 40,000
- ☐ $40,001 – 50,000
- ☐ $50,001 – 60,000
- ☐ $60,001 – 70,000
- ☐ $70,001 – 80,000
- ☐ $80,001 – 90,000
- ☐ More than $90,000

Responsible Party Information

The responsible party is the person who will pay for the visit and is financially responsible for all bills.
Only complete this section if the responsible party and the patient are not the same person.

Relationship of Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: _____
Name: _____ Sex: ☐ M ☐ F
Street Address or PO Box: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Employer: _____ Date of birth: _____ Social Security #: _____

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
MRN: _____

Insurance Information

PRIMARY INSURANCE

Plan Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security No.: _____ Sex: ☐ M ☐ F

Policy Holder's Date of Birth: _____ Employer: _____

SECONDARY INSURANCE

Plan Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security No.: _____ Sex: ☐ M ☐ F

Policy Holder's Date of Birth: _____ Employer: _____

PLEASE SIGN AND DATE BELOW, EVEN IF UNINSURED

Payment Policy: CCHC requires payment on the day of service. This payment includes outstanding deductibles, co-payments, non-covered services, sliding fee payments and any charges remaining after insurance has made payment on your account. Please be advised that your insurance may not cover all of your charges and that you are responsible for any balance on your account and will be billed until that balance is paid. The Sliding Fee Program is available for families with low incomes. This program allows patients to get a discount on their charges. You must apply with registration staff with documentation of total income and number of persons in the household. You must reapply for the program every year and payment must be made at time of service. Signing of this form indicates you are aware of above policies and procedures and were advised of the sliding fee program. I hereby authorize assignment of all insurance benefits payable directly to CCHC.

_____ _____

Patient/Guardian Signature Date

Referrals/Option to Choose: CCHC is a primary care provider and is not equipped to provide all medical services that may be appropriate for your medical care. In some cases, CCHC may recommend that you receive additional medical services, such as laboratory services, imaging services or specialty care from another healthcare provider. In the event that this does occur, please be advised that you may be required to pay on the day of service and/or be billed for any balance on your account with the referral provider.

_____ _____

Patient/Guardian Signature Date

Authorization for Release of Information: I authorize Charlotte Community Health Clinic to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify Charlotte Community Health Clinic in writing of any information I do not want released.

_____ _____

Patient/Guardian Signature Date

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Patient Rights and Responsibilities: I acknowledge that I have received and been given an opportunity to read a copy of the Charlotte Community Health Clinic's Notice of Privacy Practices and Patient Rights and Responsibilities.

_____ _____

Patient/Guardian Signature Date

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
MRN: _____

Medical Information (HIPAA) Release

Name: _____ Date of Birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to my:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Phone Messages

Please call my:

- ☐ Cell Phone: _____
- ☐ Home Phone: _____
- ☐ Work Phone: _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Other: _____

The best day(s) and time(s) to reach me are: _____

_____ _____

Patient/Guardian Signature Date

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
MRN: _____

Health History

Name: _____

Age: _____ years

How would you rate your overall health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Main reason for today's visit: _____

Other concerns: _____

_____

_____

In the last two weeks, have you had any of the following? Check all that apply.

General Health:
- ☐ Fevers/sweats/chills
- ☐ Unexplained fatigue or weakness
- ☐ Unexplained weight loss or weight gain

Eyes, Ears, Nose, Mouth, Throat:
- ☐ Changes in vision
- ☐ Difficulty hearing or ringing in ears
- ☐ Hay fever or allergies
- ☐ Trouble swallowing

Respiratory:
- ☐ Coughing or wheezing
- ☐ Coughing up blood

Cardiovascular:
- ☐ Chest pain or discomfort
- ☐ Palpitations or irregular heartbeat
- ☐ Shortness of breath with physical activity
- ☐ Swelling in legs or feet

Gastrointestinal:
- ☐ Heartburn or acid reflux
- ☐ Blood in stools
- ☐ Nausea, vomiting, or diarrhea
- ☐ Change in bowel habits

Skin:
- ☐ Skin rash or lesions
- ☐ New mole or change in mole

Endocrine:
- ☐ Heat or cold intolerance
- ☐ Dry skin
- ☐ Thinning hair
- ☐ Increase in thirst or appetite

Musculoskeletal:
- ☐ Muscle or joint pain
- ☐ Back pain (new onset)
- ☐ Back pain (chronic)

Genitourinary:
- ☐ Painful/bloody urination
- ☐ Leaking urine
- ☐ Frequent urination
- ☐ Nighttime urination
- ☐ Discharge from penis or vagina
- ☐ Testicular pain or swelling
- ☐ Unusual vaginal bleeding
- ☐ Irregular menstrual periods

Breast:
- ☐ Breast lump
- ☐ Nipple discharge

Neurological:
- ☐ Headaches
- ☐ Memory loss
- ☐ Fainting
- ☐ Dizziness
- ☐ Numbness or tingling

Hematologic:
- ☐ Unexplained lumps or swollen glands
- ☐ Easy bruising or bleeding

Emotional:
- ☐ Anxiety or stress
- ☐ Trouble sleeping
- ☐ Sadness or depression

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
MRN: _____

Health History

Medications

List all prescriptions and non-prescription medicines you take, including vitamins, home remedies, birth control pills, herbs, etc. You can also attach a medication list on a separate piece of paper.

Medicine:	Dose (mg):	How many times per day?

Allergies

List all reactions that you have to medications, foods, and/or animals.

Allergy:	How do you react to this allergy?

Medical History

Have you had any of the following medical conditions? If yes, include the year that you were diagnosed.

Heart attack	☐ Yes	☐ No	Year:	High blood pressure	☐ Yes	☐ No	Year:
Stroke	☐ Yes	☐ No	Year:	Diabetes	☐ Yes	☐ No	Year:
Thyroid problems	☐ Yes	☐ No	Year:	Seizures	☐ Yes	☐ No	Year:
Stomach ulcer	☐ Yes	☐ No	Year:	Kidney disease	☐ Yes	☐ No	Year:
Asthma	☐ Yes	☐ No	Year:	Cancer	☐ Yes	☐ No	Year:
COPD or Emphysema	☐ Yes	☐ No	Year:	Hepatitis	☐ Yes	☐ No	Year:
Mental health problem	☐ Yes	☐ No	Year:	HIV/AIDS	☐ Yes	☐ No	Year:
Blood disorder	☐ Yes	☐ No	Year:	High cholesterol	☐ Yes	☐ No	Year:

Other: _____

Surgical History

List all prior operations. Include the date that the surgery occurred.

Surgery:	Date:

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
MRN: _____

Health History

Family History

Is your mother alive? ☐ Yes ☐ No If no, what was the cause of death? _____
Is your father alive? ☐ Yes ☐ No If no, what was the cause of death? _____

Has anyone in your family, including your mother, father, grandparents, siblings, and children, had any of these medical conditions? If yes, please write how they are related to you.

☐ I can't answer these questions because I'm adopted.
☐ I can't answer these questions because I don't know my family's medical history.

Heart attack	☐ Yes	☐ No	Who:	High blood pressure	☐ Yes	☐ No	Who:
Stroke	☐ Yes	☐ No	Who:	Diabetes	☐ Yes	☐ No	Who:
Thyroid problems	☐ Yes	☐ No	Who:	Seizures	☐ Yes	☐ No	Who:
Stomach ulcer	☐ Yes	☐ No	Who:	Kidney disease	☐ Yes	☐ No	Who:
Asthma	☐ Yes	☐ No	Who:	Cancer	☐ Yes	☐ No	Who:
COPD or Emphysema	☐ Yes	☐ No	Who:	Hepatitis	☐ Yes	☐ No	Who:
Mental health problem	☐ Yes	☐ No	Who:	HIV/AIDS	☐ Yes	☐ No	Who:
Blood disorder	☐ Yes	☐ No	Who:	High cholesterol	☐ Yes	☐ No	Who:

Other: _____

Tobacco, Alcohol, and Drug Use

Have you ever smoked?

☐ Yes, I currently smoke
- When did you start smoking? _____ How many packs per day do you smoke? _____
- Are you interested in quitting? _____ Have you tried to quit before? _____
- If you've tried to quit, what method(s) did you use? _____

☐ Yes, but I've quit smoking
- When did you start smoking? _____ When did you quit smoking? _____

☐ No, I've never smoked

Have you ever vaped or used e-cigarettes?

☐ Yes, I currently vape or use e-cigarette
- When did you start vaping? _____ Are you interested in quitting? _____

☐ Yes, but I've quit vaping or using e-cigarettes
- When did you start vaping? _____ When did you quit vaping? _____

☐ No, I've never vaped

Do you drink alcohol?

☐ Yes, I currently drink alcohol
- Number of beers per week: _____ Number of glasses of wine per week: _____
- Number of liquor drinks per week: _____ Are you concerned about your drinking? _____
- Have others told you that you drink too much? _____

☐ No, I do not drink alcohol

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
MRN: _____

Health History

Have you ever used recreational drugs, like marijuana, cocaine, heroin, or other non-prescription drugs?

- ☐ Yes, I currently use recreational drugs
  - Which drugs do you use? _____
  - Do you ever use needles to inject drugs?_____
- ☐ Yes, I have used recreational drugs in the past
  - Which drugs did you use?_____
  - When did you stop using drugs? _____
  - Did you ever use needles to inject drugs? _____
  - If yes, when was the last time? _____
- ☐ No, I've never used recreational drugs

Sexual History

Sexual partner(s):

- ☐ Men
- ☐ Women
- ☐ Both men and women

How many sexual partners have you had in the past 12 months? _____

Do you have menstrual periods?

- ☐ Yes
- ☐ No

If yes, first day of last menstrual period: _____

Do you use contraception or birth control?

- ☐ Yes
- ☐ No

If you do use contraception or birth control, what kind?

_____

Safety

Do you have access to firearms or guns?	☐ Yes	☐ No
Do you ever feel unsafe in your relationship with your partner/significant other?	☐ Yes	☐ No
Do you ever feel unsafe in your relationship with your family?	☐ Yes	☐ No
Are you currently feeling sad or depressed?	☐ Yes	☐ No
Are you currently being treated for depression or other mental health issues?	☐ Yes	☐ No

Personal Information

What is your highest level of education? _____

What is your occupation?_____

Who lives at home with you?_____

What animals live in your home with you? _____

Have you ever served in the military? _____

What are your religious preferences? _____

How many children do you have? _____

_____ _____ _____

Patient/Guardian Printed Name | Patient/Guardian Signature | Date

-Please continue onto the next page-

Charlotte Community Health Clinic

Medical, Behavior Health and Dental Appointment Agreement*

**Please write your initials next to each of the following statements:*

____ New Patients: Please arrive thirty (30) minutes early for patient registration.

____ Emergencies/Urgent:

Medical/BH: Patients are only allowed one (1) emergency/urgent appointment before the new patient appointment.

Dental: Patients are only allowed one (1) emergency appointment as a new patient. The next appointment will be for a comprehensive exam.

____ Sliding Fee Scale:

Dental: Proof of your card from CCHC is required at the first appointment. For patients that are not part of CCHC, you are required proof of insurance. If you don't have coverage you will be charge our full fee until income information is provide to us or you can be seen under our walk in policy. All documents need to be updated yearly.

Medical/BH: Proof of income or Insurance will be required at the first appointment. If you don't have coverage or proof of your income for the first visit you will be charge our full fee until income information is provide to us. All documents need to be updated yearly.

____ Late Arrival:

Medical/BH: If you arrive more than ten (10) minutes late for your appointment, you may be asked to reschedule or be worked into a vacant appointment.

Dental: If you arrive more than fifteen (15) minutes late for your appointment, you may be asked to reschedule or be worked into a vacant appointment.

____ Cancellations:

Medical/BH/Dental: When cancelling an appointment, you must give at least twenty-four (24) hour' notice. When a patient misses an appointment, we miss the opportunity to care for the patient as well as another patient who could have used that appointment slot.

-Please continue onto the next page-

CHARLOTTE COMMUNITY HEALTH CLINIC

____ No Show:

Medical/BH/Dental: (1) If an appointment is missed completely, (2) when the patient is **more than 10 minutes late in Medical** or **15 minutes late in Dental** by the clinic clock, and has not called one full day (24 hrs) ahead of the appointment to reschedule, it's a No Show.* When a patient accumulates three (3) no show appointments consecutive in Medical or two (2) broken appointments in Dental, that person will not be allowed to schedule ANY further routine/ follow up appointments for a period of six (6) month following the third consecutive no show in Medical or the second broken appointment on Dental. Example:

____ Medical/ BH

I. **First No Show**: A note will be placed in the chart and the patient will verbally reminded of our policy.
II. **Second No Show:** A note will be placed in the chart and the patient will verbally reminded again of our policy.
III. **Third No Show:** Patient will not be allowed to make appointments in advance for a period of six (6) months.

____ Dental

I. **First Missed Appointment:** A note will be placed in the chart and the patient will verbally reminded of our office policy.
II. **Second Missed Appointment:** The patient will not be allowed to schedule another appointment for six (6) months.
III. **Third Missed Appointment:** The patient will not be allowed to make advance appointments for a period of one (1) year, except for emergencies.

- **If a patient is schedule with another family member and the both fail to show for their appointments, the family will no longer be able to schedule multiple appointment on the same day.**

I understand and agree to abide by Charlotte Community Health Clinic Appointment Agreement

Patient/Parent Signature: _____ Date: __/__/__

Witness Signature: _____ Date: __/__/__

MRN: _____

Thank you for completing our New Patient Application! Please send the PDF to:

financial.docs@cchc-clt.org