Thank you for continuing to choose CAHN to meet your healthcare needs and serve as your Medical and Dental Home. It is our goal to provide you with exceptional, individualized quality care you need and deserve. Please provide your most up-to-date information.

Patient Name:_____ **Previous Name:**_____ **Date of Birth:**_____

Social Security Number:_____ **Marital Status:**_____ **Email:**_____

Address:_____**City:**_____**State:**_____ **Zip Code:**_____

Home Phone: (____)_____ **Work Phone: (____)**_____ **Extension:**_____ **Cell Phone: (____)**_____

PATIENT DEMOGRAPHICS

Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ Caucasian

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Are you a twin/multiple**: ☐ Yes ☐ No

Language: ☐ English ☐ Spanish ☐ Other

Sexual Orientation: ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Something Else

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female- to Male ☐ Transgender Female/Male to Female ☐ Other

Please check all that apply: ☐ Migrant Worker ☐ Seasonal Worker ☐ Homeless ☐ Veteran ☐ Public Housing

Estimated Household Yearly Income: _____ **Number of people in Household** : _____ ☐ I do not wish to disclose

By declining to disclose the number of people and income for my household, I decline my right to apply for the sliding scale discount program_____
Initials

How did you hear about us?_____ Pharmacy Preference_____

Preferred method of appoint reminder and/or communication: ☐ Phone Call ☐ Text Message (SMS) ☐ Email

EMERGENCY CONTACT

Emergency contact:_____**Relationship:**_____

Home Phone: (____)_____ **Cell Phone: (____)**_____ **Work Phone: (____)**_____

RESPONSIBLE PARTY/GUARANTOR (IF PATIENT IS A MINOR)

Responsible PartyName:_____**DOB:**_____**Relationship:**_____

Address: _____**City:**_____**State:**_____**Zip:**_____

Social Security Number:_____ **Home Phone: (____)**_____ **Cell Phone: (____)**_____

INSURANCE INFORMATION ☐ **Uninsured**

Name of Insured:_____ **Relationship to Patient:**_____ **Gender: M F**

Insured's DOB_____ **Insured's SSN:**_____ **Insured's Phone: (____)**_____

Name of Employer:_____ **Work Phone: (____)**_____ **Extension:**_____

Insurance Company:_____ **Policy Number:**_____ **Group ID:**_____

DO YOU HAVE AN ADVANCED HEALTH CARE DIRECTIVE?

☐ Yes ☐ I have an existing one to add to my file ☐ No, I would like to complete one ☐ I decline at this time

*** An Advance Health Care Directive (or Advance Medical Directive) allows a person to describe his or her preference in end of life situations*

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Signature of Patient or Responsible Party: _____Date:_____

CAPITAL AREA cahn HEALTH NETWORK

Patient Name: _____ DOB: _____ SSN: _____

Consent for Treatment

- I hereby consent to and authorize treatment and care by the physician/dentist, clinical staff, employees and authorized agents of Capital Area Health Network.
- I understand that I have the right and the opportunity to make informed decisions regarding my care and treatment. I have the right to discuss the risks and benefits of any recommended procedure(s) and/or therapeutic courses of treatment along with any available alternatives. This right also includes the right to refuse any recommended treatments.
- I authorize my provider, clinical staff and all technical employees to administer any treatment or perform any procedures deemed necessary for my care and treatment.
- I agree, understand and promise to adhere to the following: In accordance with the Deemed Consent for HIV Testing (Virginia State Law) 32.1-45.1, I authorize Capital Area Health Network to test my blood for Human Immunodeficiency Virus (HIV), Hepatitis A virus, and Hepatitis C virus **in the event of an exposure** to any form of my bodily fluids in a manner which may transmit the above viruses. In the event of an exposure, I consent to such testing of these infections and the release of the test results to Capital Area Health Network employees who have been exposed. I understand that these results are required by law to be reported to the Virginia Department of Health.

_____ Initials – I have read, understand and agree to the above terms

Payment Agreement

- I agree to be responsible for payment of all services rendered to me or my dependents at Capital Area Health Network. I understand that I am responsible for all charges incurred.
- I authorize the release of my protected health information to insurance companies or other third party payors.
- I understand that my health insurance company may not pay the full amount of the fees charged by Capital Area Health Network. I agree to pay any required co-payments, co-insurance and deductibles, in addition to charges for services not covered by my insurance at the time of service unless other arrangements have been approved in advance.
- I understand that if I fail to provide Capital Area Health Network with the correct health insurance information, I will be responsible for paying all of the fees for my care.
- I understand that additional fees which my insurance company may not cover may apply. I agree to pay these fees in full.
- I understand that there is a **$35 charge** for returned checks along with the amount of the check. Persons who provide two (2) returned checks will not be eligible to pay by check for services rendered.
- I understand that if Capital Area Health Network is unable to obtain payment within a reasonable amount of time, I will be referred to a collection agency. I understand that I will be liable for all collection charges, associated legal fees, and the full balance on my account.
- By signing this document, I understand and agree that photocopies of this document shall be considered valid as the original.
- By signing this document, I acknowledge that I have read, understand and agree to the terms and conditions of this form. I understand that I will be bound by these terms.

_____ Initials – I have read, understand and agree to the above terms

CAHN Policies and Procedures

Our policies and procedures indicate the measures that we will take during any noted circumstances. By signing below, you acknowledge that you have received a copy of all of the following policies and procedures at Capital Area Health Network. If you have any questions, you have the right to request any additional information.

- Late Arrival Policy
- No-Show/Cancellation Policy
- Sliding Fee Determination Policy (if applicable)

_____ Initials – I have received, read, and agree to the above terms

PRIVACY and DISCLOSURE

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information. As provided in our Notice of Privacy Practices, the terms of our notice may change, however you may obtain an up to date copy any time at any of our locations or by contacting us at 804-780-0840. By signing below, you acknowledge that you have received a copy of our NPP.

_____	_____	_____	_____
Patient or Guarantor Signature	Patient Printed Name	Relationship to Patient	Date

☐ Patient refuses to sign Privacy and Disclosure portion of form Reason: _____

CAPITAL AREA cahn HEALTH NETWORK

Patient Name: _____ DOB: _____ SSN: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Required by the Health Insurance Portability and Accountability Act (HIPAA)

I. PERMISSION TO DISCLOSE PRIVATE HEALTH INFORMATION TO FAMILY/FRIENDS

By signing this form below, I give permission to the person(s) listed in the table documented to receive private health information about my care or other authorization as listed in the comments section from Capital Area Health Network and its affiliated healthcare providers. I understand that I may revoke my authorization at any time by submitting my request to change, add or terminate such permission in writing.

Date of Permission	Name of Individual & Relationship to Patient	Telephone Number	Comments/Instructions (i.e.; may pick up meds, may disclose test results, etc.)	Patient/ Guardian Initials

In order to obtain information by telephone, the party calling the practice must share the following patient identifier with the staff.

Patient Chosen Identifier/Password: _____

II. AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

- I authorize Capital Area Health Network, its agents or subsidiaries to release/receive all confidential healthcare records of the above listed patient.
- I understand that I have the right to revoke/cancel this authorization or limit this authorization to specific providers/facilities at any time except to the extent that prior action has been taken in reliance on this authorization. I understand that in order to revoke this authorization, I must do so in writing by notifying Capital Area Health Network prior to any actions or requests made regarding my information.
- I authorize the release of all information which may include information relating to sexually transmitted disease, AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), alcohol/drug treatment or use, behavioral or mental health services (including psychotherapy notes) and other communicable diseases. _____ Initials
- I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. Capital Area Health Network nor any affiliated healthcare providers can make me sign this authorization as a condition to obtaining treatment, making payments on any bills, or gaining eligibility for benefits unless allowed by law.
- I understand that by authorizing the disclosure of this protected health information, all of my records, including but not limited to history and physical exams, progress notes, laboratory reports, x-ray reports, immunization records, billing records and any other information pertaining to my health may be released to the identified person(s)/entities.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient, and would then no longer be protected by federal regulations.
- I understand that there is a cost for a copy of my health information. In compliance with the Virginia Statute, I agree to pay a $10.00 administrative fee for my health records in addition to a fee of $.50 per page for up to 25 pages and $.25 per page thereafter.
- This authorization will expire one (1) year from date of signature if I do not cancel it in writing prior to the expiration date. This information will not be released without the appropriate signature.
- By signing below, I agree that I have received a copy of this authorization to release my information. I understand that copying charges will be applied according to Capital Area Health Network's policies and procedures.

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient or Responsible Party: _____ Relationship (if not self): _____