Date: ______________________

# Adult New Patient Registration

1. Social Security: ______-______-______ Date of Birth: _____/_____/_______
2. Name (First and Last): ____________________________________________ M.I. _________
3. Mailing Address: _______________________________________________________
4. Apartment: _________ City/State:_______________________ Zip Code:___________
5. Home Phone: ________________ Cell Phone: ________________ Work Phone: ___________
6. Email address: ________________________________________
7. Preferred phone: ________________________ Preferred contact method: ☐**Voice** ☐**Text** ☐**Email**
8. Gender: ☐ **Female** ☐ **Male**
9. Gender Identity:
   ☐ **Male** ☐ **Female** ☐ **Transgender Male/Female to Male**
   ☐ **Transgender Female/Male to Female** ☐ **Other** ____________ ☐ **Chose not to disclose**
10. Sexual Orientation:
   ☐ **Straight** ☐ **Gay** ☐ **Lesbian** ☐ **Bisexual** ☐ **Other** ☐ **Decline**
11. Martial Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Legally Separated**
12. Are you signed up for our patient portal? ☐ **Yes** ☐ **No**
13. Do you consider yourself to be Hispanic? ☐ **Yes** ☐ **No**
14. Race (Please check one):
   ☐ **Asian** ☐ **Native Hawaiian** ☐ **Other Pacific Islander**
   ☐ **Black/African American** ☐ **American Indian/Alaska Native** ☐ **White** ☐ **More than one race**
15. What language are you best served in:
   ☐ **English** ☐ **Spanish** ☐ **Creole** ☐ **Sign Language** ☐ **Other** ______________
16. Employment Status*:
   ☐ **Unemployed** ☐ **Employed** ☐ **Self-employed** ☐ **Disabled**
   ☐ **Retired** ☐ **Part Time Student** ☐ **Full Time Student**
17. Emergency Contact Name: ________________________ Phone: ________________________
18. Relationship to Emergency contact: __________________ Preferred Pharmacy: __________________
19. Mother's maiden (last) name: __________________How did you hear about TCCH? _______________
20. In the past two years or prior to retirement or disability have you or your head household worked in agriculture?
   ☐ **Yes** ☐ **No**
21. As a Federally Qualified Health Center we are required to ask your approximate Monthly Income (before taxes):
   __________
22. Number of people supported in household: _________
23. Do you have any type of insurance? ☐ **Yes** ☐ **No**
24. If yes, primary insurance name: ______________________________ ID#: __________________
25. Secondary insurance name: ____________________________ID#: ______________________
26. Are you homeless**? ☐ **Yes** ☐ **No**
   If yes, choose one of the following: ☐**Shelter** ☐**Transitional** ☐**Doubling Up** ☐**Street** ☐**Other**
27. Do you live in Section 8 Public Housing? ☐ **Yes** ☐ **No**
28. Are you a military veteran? ☐ **Yes** ☐ **No**

*Employment Status:
Employed – You earn a living either working part-time or full-time for another individual, company or organization.
Self-employed – You earn a living working from your own business and not earn salary or commission from another individual.
Disabled – You receive monthly payments from the government for a disability
Retired – You have retired from working and receive a social security check monthly
Full-time/Part-time Student – You are enrolled in an accredited school on either a part-time (<12 credit hrs) or full-time (12 credit hrs or more).

**Homeless Status:
Shelter – You are living in an organized shelter for homeless persons.
Transitional Housing – You are residing in a small unit that helps a person transition from homelessness to permanent housing.
Double Up – You are living with other individuals in their home and/or apartment who are not financially responsible for you.
Street – You are living outdoors, in a car, in an encampment (tent city), in a makeshift housing/shelter. Other – You are living in a single room occupancy hotel or motel or other day-to-day paid for housing.

# PATIENT CONSENTS AND ACKNOWLEDGEMENTS

| | INITIAL |
|---|---|
| I. **Consent for Treatment**<br>I hereby give consent and authorize treatment at Treasure Coast Community Health Center, Inc. for myself, the patient. | |
| II. **Consent for Treatment of a Minor**<br>I, as the parent or legal guardian of the patient, do hereby give my consent and authorize treatment. Furthermore, I grant permission for ____________________________________________ to authorize Medical Treatment in my absence. | |
| III. **Medical Students**<br>I understand that Treasure Coast Community Health Center, Inc. supports the education of medical professionals and maintains Medical Students that may assist in relation to care. | |
| IV. **Notice of Privacy Practices**<br>I acknowledge that I have been offered and/or received the practice's Notice of Privacy which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy. | |
| V. **Release of Information**<br>• Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions or for any other purpose related to benefit payment.<br>• If I am covered by Medicaid or Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, drug and alcohol treatment and discharge summary.<br>• Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases such as HIV and AIDS.<br>I hereby permit the practice and the physicians or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, and/or healthcare operations. | |
| VI. **Disclosure to Friends and/or Family Members**<br>I give permission for my Protected Health Information to be disclosed for purposes of coordinating health care needs, communicating results, findings and care decisions to the friends and/or family members listed below: | |

| Name | Relationship | Contact Number |
|---|---|---|
| | | |
| | | |
| | | |

**You have the right to revoke whom we talk with about your health care at anytime. Please complete a new consent if you wish to add or delete a friend and/or family member.

| | INITIAL |
|---|---|
| **VII. Consent for Use and Disclosure of Protected Health Information (PHI)** | |

| | Yes | No |
|---|---|---|
| May we call your job and leave a message?<br>If yes, at what number? ___________________ | | |
| May we call your home and leave a message?<br>If yes, at what number? ___________________ | | |
| May we leave a message concerning your treatment or services rendered on your cell phone? If yes, at what number? ___________ | | |

**VIII. Treasure Coast Community Health, Inc. has a patient portal that is available to all patients.**
**Consent to contact for Appointment Reminders and Other Healthcare Communications.**

Patients in our practice may be contacted via our patient portal to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

You may set-up your patient portal at https://tcch.portalforpatients.com. The practice will provide you with a PIN to connect your account to your patient records.

**I consent to receive messages for: appointment reminders, feedback, and general health reminders/information on the patient portal**

**I understand that if at any time I use my patient portal inappropriately I will lose my rights to the Treasure Coast Community Health, Inc. patient portal.**

**IX. Cancellation Policy**

Patients that need to cancel or reschedule an appointment may do so by calling TCCH at 772-257-8224.

**Appointment cancellation requires 24-hour advanced notice.**

**X. Patient Bills of Rights**

The Patient Bill of Rights is posted in the lobby. I acknowledge that I have been offered and/or received a copy of the Bill of Rights.

**XI. HIV, Hepatitis B & C Testing**

In the event that Center staff comes in contact with my or my children's body fluids, I consent to be tested for HIV, Hepatitis B and C at no charge.

**XII. Do you have an Advance Directive or a Living Will? (for patients over 18 years of age)**

Advanced Directives are legal statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make decisions as well as who is authorized to make them. Advance directives are made and witnessed prior to serious injury.

In accordance with federal and state law, this serves as notification that we will set aside your advance directive in the event you experience a life threatening event while at one of Treasure Coast Community Health's centers and you will be transferred to a higher level of care.

By signing below, you agree and understand this as notification.

Please indicate below whether or not you have an advanced directive or if you would like to receive information on advance directives.

☐ I have an advanced directive.

☐ I do not have an advanced directive.

☐ I would like to receive information on advanced directives.

**XIII. I authorize direct payment to TCCH and all entities of TCCH for the treatment rendered and understand that I am responsible for final payment of medical services regardless of my insurance coverage.**

✖ ______________________________ ____________________

Signature of Patient or Parent/Guardian Date