COPLIN HEALTH SYSTEMS

Patient Registration

Basic Information

Last Name	First Name	MI	Preferred Name
Mailing Address	City	State	Zip

County	Cell Phone Number	Home Phone Number	Work Phone Number

Email Address	☐No-email	Preferred Method of Contact: ☐Voice on home phone ☐Voice on Cell ☐Text ☐Email
Date of Birth	Gender: ☐Female ☐Male ☐Unknown	Social Security Number

Employer/School	Employer/School Phone Number
Preferred Coplin Provider	Primary Care Provider
Preferred Pharmacy	Preferred Pharmacy Address

Responsible Party (Responsible for bill): ☐Same as Above

Name:	Date of Birth	Phone:

Relationship to Responsible Party	Mailing Address of Responsible Party

Parent/Guardian Information (court issued guardian/custody documentation is required)

Parent/Guardian	Relationship	DOB	Phone #	Email
1)____________________	1)________________	1) __________	1)________________	1)______________________________
2)____________________	2)________________	2) __________	2)________________	2)______________________________

EMERGENCY /ALTERNATE CONTACT INFORMATION: I understand that by providing an alternate contact if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact (including all relevant information with exception to psychiatric/mental health, alcohol/drugs, and HIV / AIDS information).

Name of Emergency/Alternate Contact	Date of Birth of Contact	Phone Number	Cell Number

Relationship to Contact	Address of Contact	May we leave a message? ☐Yes ☐No

Permission to Speak and Treat

I ______________________ authorize Coplin Health Systems to share my personal health information with the named persons below.

Please check the box to identify the information Coplin Health Systems is authorized to share with each named person.

Name: ____________________ Date of birth: _________ Relationship to patient: _______________ ☐*Permission to Treat
Phone: _______________________

☐ALL ☐Medical ☐Dental ☐Billing ☐Scheduling ☐Behavioral Health ☐SUDS ☐HIV/AIDS

Name: ____________________ Date of birth: _________ Relationship to patient: _______________ ☐*Permission to Treat
Phone: _______________________

☐ALL ☐Medical ☐Dental ☐Billing ☐Scheduling ☐Behavioral Health ☐SUDS ☐HIV/AIDS

Name: ____________________ Date of birth: _________ Relationship to patient: _______________ ☐*Permission to Treat
Phone: _______________________

☐ALL ☐Medical ☐Dental ☐Billing ☐Scheduling ☐Behavioral Health ☐SUDS ☐HIV/AIDS

*By checking the “Permission to Treat” box, I authorize the individual named above to accompany the listed patient for healthcare services and to consent to treatment on the patient's behalf, as necessary.

COPLIN HEALTH SYSTEMS

Patient Registration

Insurance Information ☐ I do not have insurance

Primary Insurance Name	Insurance ID Number	Group Number
Insurance Phone Number	Policy Holder Name	Policy Holder Phone Number
Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Employer
Secondary Insurance Name	Insurance ID Number	Group Number
Insurance Phone Number	Policy Holder Name	Policy Holder Phone Number
Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Employer

☐ I would like to request for information regarding Coplin Health Systems Sliding Scale Fee
☐ I would like to request assistance from Coplin Health Systems on obtaining insurance

Household and Demographic Details

Coplin Health Systems is a Federally Qualified Health Center, and we qualify for special pricing and discounted costs to our patients. To ensure that we continue to receive this designation and funding, we value gathering specific information about the population that we serve. We ask that you assist us by completing the following.

How many people are currently living in your household? (Circle one)
1 2 3 4 5 6 7 8 9

What is your estimated household monthly net income?
☐$100–500 ☐$501-$1000 ☐$1001 –$1500 ☐$1501-$2000 ☐$2001-$2500 ☐$2501-$3000 ☐$3001-$3500
☐$3501-$4000 ☐$4001-$4500 ☐$4501-$5000 ☐$5001-$5500 ☐$5501- $6000

Household Status:
☐Own my home ☐Rent ☐Live with someone ☐In Shelter ☐Transitional ☐Homeless

Marital Status:
☐Married ☐Single ☐Divorced ☐Partner ☐Widowed ☐Legally separated ☐Unknown

Military Status:
☐Not a Veteran ☐Veteran ☐Active Service

Disability Status:
Do you have a disability as identified by the Americans with Disabilities Act? ☐Yes ☐No

Student Status (For School Wellness Center (School Based Health) Locations Only:
☐Student ☐School Employee ☐Community Member

Race:
☐White ☐ Black ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander
☐Asian ☐Native American ☐Other: _____

Ethnicity:
☐Not Hispanic/Latino ☐Hispanic/Latino ☐Decline to Specify

Preferred Language
☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Other: _____

Sexual Orientation:
☐Straight ☐Lesbian/Gay ☐Bisexual ☐Other ☐Don't know ☐Choose not to disclose ☐Unknown

Gender identity:
☐Female ☐Male ☐Transgender Male ☐Transgender Female ☐Other ☐Choose not to disclose ☐ Unknown

Referral Information

I was referred to Coplin by (Person's name, provider/doctor's name)	I heard about Coplin from (A friend, social media, billboard, etc.)

Allergies

Allergies:

Current Medication and Health Information

Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:

Dental Insurance Information ☐I do not have dental insurance

Dental Insurance Name	Insurance ID Number:	Group Number
Insurance Phone Number:	Policy Holder Name:	Policy Holder Phone Number
Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Employer
Secondary Dental Insurance Name	Secondary Insurance ID Number:	Secondary Group Number
Insurance Phone Number:	Policy Holder Name:	Policy Holder Phone Number
Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Employer

Dental Information

Has a doctor ever told you that you need to take antibiotics before dental treatment because of a joint replacement, a heart problem, or another health condition? ☐Yes ☐No ☐Uncertain

Portable Dental Consent

Coplin Health Systems may utilize a portable dental unit in various locations to provide dental exams, minor dental procedures, fluoride treatments, cleaning, and sealants. Services utilized through the Portable Dental Unit will be billed to your insurance.

Please initial to provide consent **to utilize the portable dental unit (initial)** _____

Scheduled Appointment Cancellation Requirement Acknowledgement

Coplin Health Systems strives to provide access to quality care for medical, pediatrics, dental and behavioral health services. In that effort, the organization works to actively reduce missed appointments and no-show appointments which are those appointments that are not kept or cancelled prior to the time of the appointment.

To assist in ensuring patients stay alert to their scheduled appointments, Coplin Health Systems uses automated appointment reminder services that contact scheduled patients by phone, email or text. Please verify that all contact information is up to date with the patient representative when checking in for appointments.

Patients that need to reschedule or cancel an appointment are asked to notify the office where they are scheduled at least 24 hours prior to the appointment time. If this falls on a weekend, please leave a message on the office voicemail service. This will allow staff time to fill the vacancy in the provider's schedule so others in need can be seen.

Please note that if a patient misses two or more scheduled appointments without canceling at least 2 hours prior to the appointment, a letter will be sent to the patient to offer assistance in addressing possible barriers preventing the patient from keeping the scheduled appointment.

Please be aware that if a third scheduled appointment is missed without being cancelled at least 2 hours prior to the scheduled visit, the patient will only be able to be seen through available Same Day appointment openings as they are available for a twelve-month period beginning from the date of the first missed appointment that was not canceled as required. This appointment may be with a provider other than the patient's primary care provider depending on availability. This means that for the remainder of the twelve-month period, the patient can only be seen if an available same day appointment is open on the day the patient calls to schedule.

I acknowledge the Appointment Scheduling Requirements: **(initial)** _____

Special Consents

I agree to allow Coplin Health Systems access to my prescription history: ☐Yes ☐No
I agree to have nursing and/or medical students present during my care: ☐Yes ☐No
I agree to allow Coplin Health Systems to keep my credit card information on file: ☐Yes ☐No
I agree to allow Coplin Health Systems to record my visit for accuracy of documentation (This is only stored for a temporary period, and may be specifically declined during the visit for any reason, by letting the provider know): ☐Yes ☐No

Telehealth Consent

I understand that medical and behavioral health services may be provided via telehealth using two-way audio-visual technology, which differs from in-person visits, as the provider will not be in the same room. I have the right to refuse or stop participation in telehealth services at any time. Should I choose not to participate, or if the provider determines the technology does not meet the standard of care, I understand that I may need to schedule an in-person visit or seek care elsewhere, including emergency care, depending on the urgency of my condition. I understand how this technology will work, and I recognize that technical difficulties or interruptions may occur during a telehealth visit. I understand if I have questions prior to a telehealth visit, I can reach out to have those questions addressed.
During telehealth sessions, I will be informed of anyone present in the room with my provider, and such individuals will only be involved if necessary to assist in my care. I understand that providers participating in my care are licensed in the state where they are located, and if they are not licensed in the state where I am located, I still consent to receive services. I am responsible for any applicable co-pays or coinsurance. My provider may request for consent to take photographs during the session for my care. My provider may also request to record the visit which will be stored for a temporary period, to assist with documentation, which will be treated as protected health information under applicable laws. Confidentiality protections apply, except in situations involving suspected child or vulnerable adult abuse, threats of harm to self or others, or as required by law. Information may be shared within Coplin Health Systems' integrated Behavioral Health program as permitted by law.
This consent will remain in effect for one year, or until it is revoked in writing.

I understand the above notice and consent for the patient named above **to receive telehealth services**, as needed, for **medical services (initial)** _____ and/or **Behavioral Health services (initial)** _____.

Consent for Services

By signing below, I voluntarily consent to receive services from Coplin Health Systems. I understand the services may include, but are not limited to, acute care, preventive care, screening, diagnostic services, treatment, and education.
I acknowledge that I have been given access to Coplin Health Systems' HIPAA Notice of Privacy Practices, and I understand that I can obtain a copy from a Patient Representative, view it on the lobby wall, or access it on the website at www.coplinhealth.com. I understand the Notice of Privacy Practices provides information about the rights I have and how my health information can be used. My health information may be used for treatment, payment, health care operations. I understand and agree that my information will be shared with the WV and OH Health Information Networks, CommonWell, CareQuality and Surescripts. I may opt out of these exchanges in writing.
I authorize Coplin Health Systems to bill my Medicare, Medicaid and/or other insurance and accept responsibility for any charges not covered, including co-pays, deductibles, and non-covered services. I understand that if my insurance information is not correct, or I do not have insurance, that I am responsible for charges. I understand that Coplin Health Systems has a sliding fee discount program, and I can complete an application to see if I would qualify which is based only on income and household size. I understand that no patient will be denied health care services due to an individual's inability to pay. I permit my information to be used for claims processing, care coordination, or audits.
I agree that Coplin Health Systems may use the contact information provided for communication related to appointments, billing, or other health matters. I will protect the confidentiality of my patient portal login, to ensure my privacy. I certify that all the information I have provided is accurate and that I am consenting to treatment for myself or the identified patient. I understand I may withdraw consent in writing at any time, except for services already provided. I understand this registration is valid for 12 months unless I provide notice otherwise.

Print Name or Responsible Party	
Signature	Date: