PATIENT REGISTRATION (COMPLETE BOTH SIDES)

PATIENT INFORMATION	**TODAYS DATE**				
Last Name		First Name		M.I.	
Date of Birth		Social Security No.	- -		
Street Address		Apartment/Unit#			
Mailing Address					
City		State		ZIP Code	
Home Phone		Work Phone		Cell Phone	

May we leave phone messages for you? ☐ **Yes** ☐ **No** **If Y- Please Circle The Best Number Above To Contact You**

OK to text information? Yes No	OK to email information? Yes No	Sign up for CHA Patient Portal Yes Email:

Gender at Birth	Male Female	Current Gender Identity	Male Female Transgender Male Transgender Female Other Chose not to disclose	Sexual Orientation	Lesbian or Gay Straight Bisexual Other Don't know Chose not to disclose

Race	African American/Black Alaskan Native/American Indian More than one race Asian Caucasian/White Pacific Islander Native Hawaiian Refuse to provide
Ethnicity	Hispanic/Latino Not Hispanic/Latino Refuse to report Preferred Language?
Marital Status	Single Married Partner Separated Divorced Widowed

If minor, parent or guardian name	Relationship

Custodial Responsibility, if applicable	Joint Sole Other *(please explain)* : ______________________________ *Other Biological Parent Name:* ________________________________ ***PLEASE PROVIDE CUSTODY FORMS & PHOTO ID***		
Housing Status	Not Homeless Homeless If Homeless: Transitional Housing Shelter Permanent Supportive Housing Doubling Up Street	Military Status	Veteran Yes No

If employed in agriculture: Migrant Seasonal Employed Year Round

Employer		Occupation	
Preferred Pharmacy			

EMERGENCY CONTACT

Name		Relationship			
Home Number		Cell Number		City/State	

Coastal Health Alliance

PATIENT REGISTRATION (Page 2)

CURRENT HEALTHCARE PROVIDER		
Is CHA your primary source of healthcare?	Yes No	*If No – please list:*
Is CHA your primary source for dental care?	Yes No	*If No – please list:*
Do you have medical insurance: Yes No	Do you have dental insurance: Yes No	
PRIMARY MEDICAL INSURANCE		
SECONDARY MEDICAL INSURANCE – if appropriate		

FINANCIALLY RESPONSIBLE PARTY, *if patient is a minor, complete this section*			
Last Name	First Name		
Address (if different)	City	State	Zip
Date of Birth	Social Security Number		
Home Phone	Cell Phone	Work Phone	
Relationship to patient Mother Father Other, please state			

The income information requested below is very important for continuation of our funding as a federally qualified health center and also provides information that helps us better serve our patients. All information will remain confidential.

Please circle both your household size and household monthly Income range below.

Monthly Income Range

Number of persons in household	Less than or equal to	Less than or equal to	Less than or equal to	Less than or equal to	Less than or equal to	Equal to or Above
1	$1,073	$1,342	$1,610	$1,878	$2,147	$2,148
2	$1,452	$1,815	$2,178	$2,540	$2,903	$2,904
3	$1,830	$2,288	$2,745	$3,203	$3,660	$3,661
4	$2,208	$2,760	$3,313	$3,865	$4,417	$4,418
5	$2,587	$3,233	$3,880	$4,527	$5,173	$5,174
6	$2,965	$3,706	$4,448	$5,189	$5,930	$5,931
7	$3,343	$4,179	$5,015	$5,851	$6,687	$6,668
8	$3,722	$4,652	$5,583	$6,513	$7,443	$7,444
Over 8 people, add per person	$373	$467	$559	$653	$747	

Signature:____________________________________ **Date:**__________________________

PATIENT CONSENT & AUTHORIZATION FORM FOR DISCLOSURE OF HEALTH INFORMATION BY CHA

Coastal Health Alliance

Full Name		Date of Birth	

Coastal Health Alliance takes the privacy of your health information very seriously. As a courtesy to you, we bill your insurance company and must share certain information with the insurer in order to process claims.

MEDI-CAL PATIENTS
The Qualified Service Organizations (QSO) listed below contract with the State of California to provide health care services to Medi-Cal members. Medi-Cal may assign you to one of the QSOs for the management of your services. The QSOs process claims for services submitted by CHA. The QSOs are also required to submit information on all claims paid or processed to California Medi-Cal for administration purposes.

I authorize CHA to disclose my health information, including information related to my treatment for alcohol and/or drug abuse, to one of the QSOs listed below to which I have been assigned for the purpose of submitting claims for payment to the QSO and to other organizations for continuity of care.

- Beacon Health
- Medical Consultants
- Hospitals
- Partnership Health Plan
- Kaiser Permanente

ALL OTHER INSURANCE PLANS
I hereby authorize CHA to disclose my health information, to consulting medical providers, hospitals, and other specialists for the purpose of claims processing. This may include releasing certain information related to my treatment for alcohol and/or drug abuse to my insurance payer for the purpose of submitting claims for payment.

By signing below, I acknowledge:

- My treatment may not be completed if I do not sign this form.
- I have received a copy of this signed document.
- I understand that I may revoke this authorization at any time by giving written notice to CHA, except to the extent that CHA or the QSO has already acted on it.
- This authorization will expire on the date that I am no longer a California Medi-Cal member, a member of my health plan or two years from the date of my signature, whichever is earlier.

Signature of Patient or Legal Representative		Date	
Print Name of Legal Representative (if applicable)		Relationship to Patient	
Revocation: I revoke my authorization for disclosure of Substance Use Disorder information to my payer(s).			
Signature of Patient or Legal Representative		Date	

Coastal Health Alliance (CHA) is dedicated to providing high quality primary health care to the entire community. Part of doing that is getting started with a good understanding of the "ground rules" of providing you with that care. To provide you with treatment and bill your insurance for those services, please read this entire form and sign below to show that you agree with the following statements. If you have any questions, please ask them before you sign this form.	
Consent to Treatment	By signing below, you agree CHA employees and health care providers can examine you, take specimens like blood or urine and administer routine tests like x-rays or heart monitoring. Before more invasive tests or treatments take place, we will talk with you about their specific risks and possible benefits and may ask you to sign another form once your questions have been answered.
Consent to pharmacy history	By signing below, you agree to allow CHA employees and health care providers to retrieve and review your prescription history from outside sources or entities. **If you wish to decline**, please sign here: ________________________________
Payment for Services	By signing below, you agree to pay for services provided by CHA at the time they are rendered, including your co-payment, co-insurance or deductible; unless some other arrangement is agreed to by CHA. You also agree that you are responsible for all charges, whether or not some part of them is paid by insurance.
Insurance – Assignment of Benefits	By signing below and providing us with your insurance information, you approve CHA's submission of claims to your insurance plan, Medicare, Medi-Cal or any other insurance plan or program that may pay for your care. You also assign the benefits from such insurance or programs to CHA and agree that the benefits can be paid directly to CHA. You also agree to cooperate with CHA in filing such claims and provide us with any changes to information related to you, your eligibility or coverage under a particular policy or program.
Financial Assistance	**CHA has sliding fee discount program based on family income**. To apply for this, you must provide proof of your income, such as pay stubs, unemployment benefit awards, AFDC, tax returns, alimony checks, pension statements, etc. By signing below, you agree that CHA has provided you with notice about this policy.
Notice of Privacy Practices	**CHA has a Notice of Privacy Practices** which describes your rights and how information that you provide to us may be used to treat you, bill for that treatment and operate CHA. By signing below, you agree that a copy of Notice of Privacy Practices has been given to you. □ Patient declined to receive copy of Notice of Privacy Practices

Signature:________________________________ Date:___________

(Patient or Patient Representative – Parent, Guardian, Power of Attorney – circle which)

You are entitled to a copy of this form once you have signed it – just ask us.
Thank you for choosing Coastal Health Alliance!

Coastal Health Alliance

FINANCIAL DISCLOSURE AGREEMENT

CHA offers a number of ways to pay for the services we provide. Payment is expected at the time of service. If this is not possible, arrangements need to be made for payment. If you have no health insurance coverage or a large deductible and your income is below a certain amount, you might be eligible for our sliding fee program or other government funded programs. The payment options available include the following:

If you have INSURANCE: We will need copies of your current insurance plan card. Please know your health care coverage. Each plan is different. At the beginning of the year, many people have deductibles. Until your expenses for the year reach the deductible amount, you must pay at the time of service. You might also have a co-payment with each visit. For any non-covered services, you will need to pay at the time of service. Once you have met your deductible amount and any applicable co-payments, we will collect payment from the insurance company.

If you have an HMO Insurance: Make sure one of our doctors is your Primary Care Physician and know which medical group he/ she is affiliated with. If we are not your Primary Care Physician and your services were not authorized by your PCP you must pay at time of service.

If you have Medicare: We need copies of your Medicare and supplemental insurance plan cards on file. If your Medicare benefits have been transferred to an HMO plan (Kaiser Senior Advantage, Scan, Western Health Advantage, Health Net, etc.) make sure one of our doctors is your Primary Care Physician and know which medical group he/she is affiliated with. You will need to make your office visit co-pay at the time of service.

If you have MediCal or Partnerhsip Health Plan : We must see your card at the time of service. If we cannot confirm your eligibility, you must pay at the time of service. For Partnership Health Plan members make sure one of our doctors is your Primary Care Physician. If you have not been assigned a PCP please inform the front desk.

If you do not have insurance, Medicare, MediCal, we require payment at the time of service. With our "Direct Pay" option, you may pay in full, or sign up for a payment plan.

This option can be used when patients prefer to have their insurance companies billed first, before making any payments themselves. It can also be used by patients who have no health insurance and would like to set up a payment plan to pay their bill. Your signature on the "Direct Pay" form authorizes the clinic to bill your Visa or MasterCard credit card or debit card for the portion of your bill not paid by your insurance. The Financial Specialist will set this up for you.

A prompt pay discount will be applied to private pay patients only who pay in full for today's services via cash or credit/ debit card.

Delinquent accounts may be referred for collection.

Signature:________________________________ Date:___________