CLINCH RIVER HEALTH SERVICES, INC.

17285 Veterans Memorial Hwy.
Dungannon, VA 24245

Phone: 276-467-2201 Fax: 276-467-2673
Website: www.crhealth.org

New Patient Checklist:

1. ______ Patient Registration Form
2. ______ General Consent and Telehealth Form
3. ______ Communication Form
4. ______ New Patient Information Medical Sheet
5. ______ Informed Counseling Agreement
6. ______ Controlled Statement
7. ______ Sliding Fee Application with Proof of Income
    - This may be filled out even if you have insurance to possibly help lower your cost and possibly receive lower lab cost.
    -
8. ______ Release of Information/Authorization
    - Please complete section for Patient Information and Signature(we will use information listed below to complete form)

*********_**List Previous Providers including Specialist you have seen in last 5 years**_*******

Name of Provider	City/State	Phone	Fax

Executive Leadership

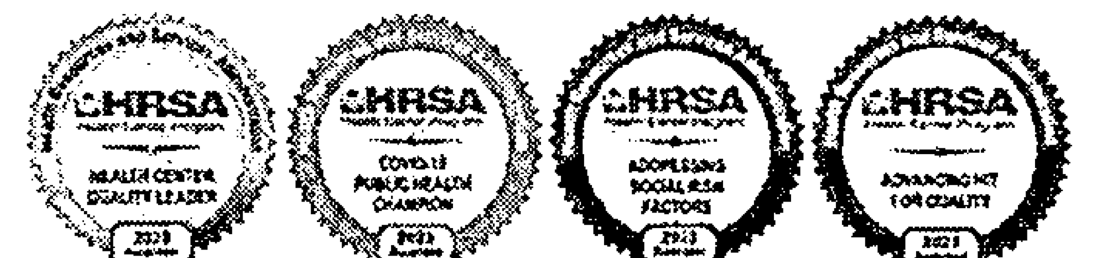
Gary W. Gilliam, FNP, Chief Executive Officer
Todd A. Cassel, M.D. Chief Medical Officer
Crystal D. Ball, FNP, Chief Operations Officer

Medical Providers

Abagail Farmer, FNP
Sutton Hess, FNP
Mikella Maine, FNP
Julie Meade, FNP
Taylor Salyers, FNP

Behavioral Health Providers

Rachel Burke, PMH-NP
Melissa Dye, LCSW
Hannah McNew, LCSW



Clinch River Health Services

REGISTRATION FORM PATIENT INFORMATION

Name_______________________SSN _______________________DOB__________

Mailing Address_______________________City/State _______________Zip __________

Physical Address (if different from above)_______________________City/State_______________Zip__________

Home Phone_______________________Cell Phone_______________________

Email Address _______________________ ☐REFUSED ☐NONE

PATIENT PORTAL: Patients with email addresses listed on the registration form will automatically register with our patient portal which can be accessed by visiting our website**: www.crhealth.org** or downloading the **HEALOW app.**

Sexual Orientation: Please Check the Correct Choice ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Choose not to disclose
Gender Identity: Please Check the Correct Choice ☐ Male ☐ Female ☐ Transgender Male/ Female to Male ☐ Transgender Female/ Male to Female ☐ Choose not to disclose
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Race: ☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ American Indian ☐ Hispanic (all Races) ☐ Alaska Native
Residence: Are you a seasonal resident? ☐ Yes ☐ No Are you a migrant worker? ☐ Yes ☐ No Are you homeless? ☐ Yes ☐ No

Are You a Veteran: ☐ Yes ☐ No Number of People in Household_____

Estimated Household Income: CIRCLE one Below $14,580K $14,581-$19.720 $19,721-$24,860
$24,861-$30,000 $30,001-$35,140 $35,141-$40,280 $40,281-$45,420 $40,281-$45,420
$45,421-$50,560 ABOVE $50,561

PATIENT SPOUSE/GUARDIAN INFORMATION Spouse/Guardian ☐ N/A

Name_______________________

Address_______________________City_______________State________Zip__________

Relationship_______________________Phone_______________________

Employer_______________________Phone_______________________

INSURANCE INFORMATION ☐ N/A GUARANTOR NAME_______________________ GUARANTOR DOB:__________

Primary Insurance_______________________Insured Name _______________________

Insured ID Number_______________________Group Number _______________________

Secondary Insurance_______________________Insured Name_______________________

Insured Id Number_______________________Group Number_______________________

RESPONSIBLE PARTY OF ACCOUNT (if different from patient) ☐ SAME

Name_______________________SSN_______________________

Address_______________________City_______________State__________Zip__________

Employer_______________________Phone_______________________

Employer Address_______________________ City____State__________Zip__________

EMERGENCY CONTACT (Nearest Relative not living with you)

Name_______________________Relationship___ Address_______________________

City_______________________State__________Zip__________Phone __________

DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL): ☐ YES, please provide us with a copy ☐ NO

SIGNATURE:_______________________ **DATE:** _______________________

Clinch River Health Services

GENERAL and TELEHEALTH CONSENT FOR TREATMENT

NAME: ______________________________ **DOB:** ________________ **SSN:**______________________

1.CONSENT TO FILE INSURANCE/CORRECT INFORMATION: I authorize the release of all medical information necessary to process my insurance claims. I permit a copy of the authorization to use in place of the original. I authorize Clinch River Health Services to file my insurance for services rendered. I request that payments be made directly to Clinch River Health Services, Inc. I certify that the information that I have reported about my insurance coverage and my personal information is correct. I understand that I am responsible for all balances that my insurance company does not pay. I understand that claims may be filed electronically through a safety net internet portal. **INITIALS:**______

2. HIPAA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received and read the CLINCH RIVER HEALTH SERVICES HIPAA Notice of Privacy Practices. **INITIALS:** _______

3. PATIENT RIGHTS AND RESPONSIBILITIES: I have received a copy of the patient rights and responsibilities. **INITIALS:**_______

4. CONSENT FOR TREATMENT: I, ________________________________, give my consent for the medical staff of Clinch River Health Services, INC. to perform emergency medical treatment, acute or chronic medical treatment, preventive healthcare, behavioral/mental healthcare, and health maintenance care as deemed medically necessary. **INITIALS:** ______

5.TREATMENT: We may use and disclose protected health information (PHI) (including alcohol and drug abuse diagnoses protected by Title 42 of CFR) about you to provide, coordinate, and manage your treatment and related services. This includes the coordination or management of your health care with CRHS staff or a third party for treatment purposes. This also includes releasing PHI where required by law. Records may be reviewed by state or federal licensure, funding, and other regulatory authorities as authorized by state and federal law and related regulations.

INITIALS: ______

6. DEEMED CONSENT FOR BLOOD TESTING:I understand that under Virginia Law, if a health care provider, a person employed by, under the direction of, or control of a healthcare provider is directly exposed to bodily fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patients will be deemed to have consented to testing for HIV or Hepatitis B or C and the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) A patient who tests positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling. **INITIALS:** _______

7. INTEROPERABILITY CONSENT: Providing us access to your Electronic Health Record (EHR) from participating hospital systems and other care center(s) allows us to better serve you by being able to access important health information. Examples: Allergies, Lab Reports, ETC. By initially below, I give CLINCH RIVER HEALTH SERVICES permission to access your EHR information from other entities, including but not limited to hospitals and other care facilities. **INITIALS:** ______

8. RX HISTORY CONSENT: Providing us access to your Medication History from pharmacies allows us to document the list of your current medications, assess drug-to-drug/drug-to-allergy interactions and obtain insurance coverage information for your prescriptions quickly and efficiently. By initialing below, I give CLINCH RIVER HEALTH SERVICES permission to access my Medication History from external databases (like Pharmacies) to better process medications. **INITIALS:**______

9. TELEHEALTH SERVICE if offered: I, ________________________________, agree to receive audiovisual medical/behavioral services. I understand that the health care provider is located at **CLINCH RIVER HEALTH SERVICES 17285 VETERANS MEMORIAL HWY DUNGANNON, VA** while I am located at a different location. I also understand that:

- I can decline the Telehealth Service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled to cannot be taken away
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth Service.
- I will have access to all medical information resulting from the Telehealth Service as provided by law.
- The information from the Telehealth Service cannot be released to researchers or anyone else without my additional written consent.
- I will be informed of all the people who will be present at all sites during my Telehealth Service.
- I may exclude anyone from any site during my Telehealth Service.
- I also understand that my insurance will be billed for this visit and that I may be billed for what my insurance does not cover. I understand that if I have any questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third-party payor.

PATIENT SIGNATURE: ____ **DATE:** _______________

PARENT/GUARDIAN SIGNATURE:______________________________ **DATE:** ________________

WITNESS SIGNATURE: _______________________________________ **DATE:** _______________

(THIS CONSENT FORM WILL BE USED AS NEEDED. YOU MAY REVOKE OR CHANGE AT ANYTIME.)

Clinch River Health Services

Patient Preferences for Receiving Communication

PATIENT NAME: ______________________ DATE OF BIRTH: ______________

Please contact me as follows: [ ] Home [ ] Cell [ ] Work [ ] Other Number: ______________

You may choose any that apply:

[ ] Leave detailed message
[ ] Leave call-back number only
[ ] Do not leave message
[ ] Written Communication
[ ] Mail to: [ ] Home [ ] Other Mailing address: ______________________

You have my permission to discuss my care with:

Name: ______________________ Relationship: ____________ Phone: __________
Name: ______________________ Relationship: ____________ Phone: __________
Name: ______________________ Relationship: ____________ Phone: __________

You have my permission to discuss my account balance and billing with:

Name: ______________________ Relationship: ____________ Phone: __________
Name: ______________________ Relationship: ____________ Phone: __________
Name: ______________________ Relationship: ____________ Phone: __________

______________________________ ______________

Patient/Legal Guardian Signature Date

______________________________ ______________

Witness Signature Date

Clinch River Health Services

NEW PATIENT INFORMATION

Name________________________________

General State of Health: Excellent Good Fair Poor

Martial Status: Single Married Separated Divorced

Occupation or Job ________________________

Number of Children______________________

Number of People in Household ____________

Do you Smoke? YES NO

_______ Packs per day _____Number of years smoking

Do you drink alcoholoic deverages? YES NO

How much per day? ______________________

Do you use illegal drugs? YES NO
If YES please list here:_____________________

Are you on any type of special diet?___________

Religion: ___________________________

Date of Last Flu Shot______________________

Date of Last Pneumonia Vaccine______________

Date of last Shingles Vaccine________________

Date of Last Td or Tdap Immunization__________

Who was your previous Doctor? ______________

When was your last visit? __________________

When was your last physical exam?___________

Reason for switching to CRHS________________

Immediate Health Concerns_________________

Injury Related? YES NO

Work Related? YES NO

Date of Birth____________________________

Gender_________________________________

Race/Ethnic Group________________________

Allergies to Medications

____

____

____

____

Other Allergies

____

____

____

Previous Hospitalizations (Please include date)

____

____

____

Have you been seen by any specialist? YES NO

If YES, list here:

1. ______________________
2. ______________________
3. ______________________

FEMALE HISTORY

Age at onset of periods_______________

Are your periods regular______________

# of Pregnancies_____ # of Miscarriages_____

Date of last menstrual period__________

Are you pregnant? YES NO

Form of Birth Control_______________

Age of Menopause_________________

Do you do self-breast exams? YES NO

Any urinary incontinence? YES NO

MALE HISTORY

Erectile Dysfunction? YES NO

Any Urinary Incontinence? YES NO

Elevated PSA? YES NO

Prostate Cancer? YES NO

Do you do self0-testicular exams? YES NO

PAST MEDICAL HISTORY

Have you had any of the following illnesses or disorders?
(Circle all that applies)

Heart Problems
High Blood Pressure
Diabetes
Overweight
Stroke
Chronic Bronchitis
Emphysema
Asthma
Tuberculosis
Hepatitis
Ulcer
Kidney Stone
Urinary Infections
Seizures
Migraines
Decreased Vision
Decreased Hearing
Black Lung

Birth Defects
Arthritis
Thyroid Problems
Gout
Anemia
High Cholesterol
Bleeding Problems
Glaucoma
Depression
Anxiety
Suicide Attempt
STD
Breast Cancer
Lung Cancer
Colon Cancer
Skin Cancer
Other Cancer______________
Amputations______________

FAMILY HISTORY

Is there a family history of: (Circle all that apply)

High Blood Pressure
Psychiatric Illness
High Cholesterol
Anemia
Tuberculosis
Breast Cancer

Depression
Overweight
Heart Attack
Stroke
Lung Cancer
Colon Cancer

Diabetes
Alcoholism
Bleeding Disorder
Glaucoma
Lung Problems
Stomach Cancer

Other Cancer________________________________

Family History	Age	Present Illness	Cause of Death
Mother			
Father			
Brothers			
Sisters			

SURGICAL HISTORY

(Please include dates)

____
____
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OTHER MEDICAL ISSUES NOT LISTED

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CURRRENT MEDICATIONS AND DOSAGE

(You may also attach medication list)

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PHARMACY INFORMATION

____
____
____

CLINCH RIVER HEALTH SERVICES, INC.

Informed Consent and Counseling Agreement

Patient Name: ______________________________ SSN: ____________________

Is Patient a Minor Child? ________Yes ________ No Age:_________ DOB:________________

I hereby grant permission for any diagnostic studies, testing therapy, and/or administration of psychotropic medications that may be necessary in the treatment of myself, my family, and/or my children. The treatment sessions and records are strictly confidential, except where state law requires the reporting threats of violence, harm, child abuse and neglect (from evidence or suspicions) and when information is subpoenaed by the courts.

I agree to enter the treatment process and am aware there may be a potential for emotional strains, stresses, and life changes as a result of therapeutic interventions. I understand that Clinch River Health Services does not guarantee any particular results or outcomes from the treatment process. In addition, I am aware of the alternative treatment facilities available to me.

Since this is a clinical practice and licensed facility, I recognize and therapeutic interventions that are listed above will be review by the providers involved, advanced clinical trainees, and clinical supervisors for clinical review and instructional purposes only.

I have been informed of the phone number to call in the event of an emergency after regular scheduled business hours. I understand the evacuation evits in this building are clearly marked and there is an evacuation map in each hallway in case of an emergency. My questions about treatment at Clinch River Health Services has been answered satisfactorily. If I have further questions, I understand my provider will either answer them or find answers for me. I understand I may leave treatment at any time, although I have been informed this is the best accomplished in consultation with the provider.

Consent: I have read the above information about the treatment and facility rules. I accept that it does not spell out every possible risk, benefit, or alternative associated with my treatment. I have been given the opportunity to ask questions and relay concerns to healthcare provider, which have been answered to my satisfaction. I understand that purpose of this treatment, as well as the potential risks involved, and possible alternatives. Therefore, I voluntarily consent to this treatment.

____
Patient Signature

____
Signature of Parent/Legal Guardian

____
Staff/Witness Signature

____
Date

CLINCH RIVER HEALTH SERVICES, INC.

CONTROLLED SUBSTANCE STATEMENT

The providers at Clinch River Health Services will not be issuing any new prescriptions for controlled substances and will not issue prescriptions for controlled substances for new patients even if they are already on the controlled substance. Patients will be referred to pain management or Psych management as requested by the patient.

By signing below, I acknowledge that I have read and understand the Controlled Substance Statement above.

Printed Name	Signature	Date

Witness Signature	Date

CLINCH RIVER HEALTH SERVICES, INC.

17285 Veterans Memorial Hwy.
Dungannon, VA 24245

Phone: 276-467-2201 Fax: 276-467-2673
Website: www.crhealth.org

September 18, 2024

RE: DISCOUNT PROGRAM/SLIDING FEE PROGRAM

Dear Patient:
Enclosed you will find a sliding fee application. The sliding fee program may help you reduce your account balance even if you have medical insurance. This application could also help in reducing how much you could potentially pay for labs not covered by current insurance. This will be applied to **EVERYONE** in your household. Please complete and return it **WITH PROOF OF INCOME.** Income can be any of the following:

- Check stubs
- W2 most recent tax year
- Copy of beneficiary letter from Social Security
- Previous Year Tax Return

Please complete the following application and return **WITH PROOF OF INCOME**. Thank you for allowing our facility to serve you and your family's healthcare needs. If you have any questions about the sliding program, please contact our front desk staff at 276-467-2201.

We also offer a prescription access program (PAP) to help patients with a 90-day supply of certain medications for only a $3.00 handling fee, if you qualify. Please contact Jeanie Tate at 276-467-2201 for questions on the PAP program and what medications are covered.

Thank you in advance for the opportunity to help reduce your account balances. If you are not interested in the program please write **REFUSED** on the application.

Thank You,

Mechelle Salyers
Front Office Manager

Executive Leadership
Gary W. Gilliam, FNP, Chief Executive Officer
Todd A. Cassel, M.D. Chief Medical Officer
Crystal D. Ball, FNP, Chief Operations Officer

Medical Providers
Abagail Farmer, FNP
Sutton Hess, FNP
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Julie Meade, FNP
Taylor Salyers, FNP

Behavioral Health Providers
Rachel Burke, PMH-NP
Hannah McNew, LCSW
Melissa Dye, LCSW

Name:	**Sliding Fee Eligibility Form For Uninsured And Insured Patients** **CLINCH RIVER HEALTH SERVICES, INC.** 17285 VETERANS MEMORIAL HWY DUNGANNON, VA 24245 PHONE: (276) 467-2201 FAX: (276) 467-2673
Address:	
City:	
SATE: Zip:	THIS FORM AND INCOME MUST BE RETURNED WITHIN 30 DAYS OF VISIT FOR DISCOUNT TO APPLY IF YOU ARE DETERMINED TO BE ELIGIBLE.
Telephone:	**APPLICATIONS WITHOUT INCOME OR INCOME WITHOUT AN APPLICATION WILL BE DESTROYED AFTER 30 DAYS. IF BOTH ARE NOT RECEIVED.**
Social Security #:	
Date of Birth:	It is necessary for us to ask personal questions in order to give you a discount on your medical expenses. This information will be kept on file in our clinic in strict confidence. You must verify your household income at least every 12 months. Your annual income tax return with a copy of your W-2 forms, payroll check stubs, your social security benefit Letters, retirement benefit letters, or copies of other checks you may receive can be used as proof. Your annual household income and family size will be used to calculate the level of discount you are eligible for.
Today's Date:	
Number of People Living in your home?	

What is your marital status? ☐Married ☐Widow(er) ☐Single ☐Divorced ☐Separated

Do you own or rent your home? ☐Own ☐Rent ☐Living with Someone

Amount of Annual House Hold Income?	You	Your Spouse	Your Children	Other Person(s)	Total Yearly Income For the Entire Household
Income from Place of Employment					

Do you have money in your saving account?	$	Do you have money in a checking accounting?	$

Do you have rental property, stock or certificates ☐Yes ☐No

Do you or a family member have insurances? ☐Yes ☐No Name of Ins Co:

Do you or anyone in your household receive any income from any of the following sources, and if, so how much?

Sources	You	Your Spouse	Your Children	Other Person(s)	Total Sources
Social Security					
Public Assistances					
Retirement Pension					
Rental Income					
Interest Income					
Child Support, Alimony					
Other (specify)					

Please list all members in your household as stated above, if they are to be covered by this application.				Is this person a patient at CRHS
Name:		DOB:		☐Yes ☐No
Name:		DOB:		☐Yes ☐No
Name:		DOB:		☐Yes ☐No
Name:		DOB:		☐Yes ☐No
Name:		DOB:		☐Yes ☐No
Name:		DOB:		☐Yes ☐No

I declare the above information is true, and I give Clinch River Health Services, Inc. permission to investigate any information given in this application. I authorize the release of all information which Clinch River Health Services may need to determine whether I qualify for financial assistance through the Sliding Scale Program. I understand that this information will be kept in strict confidence. **I also understand that if my income should change that I am required to notify the receptionist on my next visit.**

Signature: ______________________

If you have participated in Sliding Fee Program in the past, does the Nominal Fee that you have paid seem nominal or acceptable to you?

☐Yes ☐No **Approved By:** ________ **Income Code:** __________ **Expiration Date:** ______________

CLINCH RIVER HEALTH SERVICES

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Information				
First Name:	Last Name:	Date of Birth:	Last 4 of SSN:	
Address:		City	State	Zip Code

I AUTHORIZE CLICH RIVER HEALTH SERVICES TO OBTAIN MY MEDICAL/MENTAL/BEHAVORIAL HEALTH INFOMRATION FROM FACILITY: ______________________________

ADDRESS: ______________________________

PHONE NUMBER: ______________ FAX NUMBER: ______________

DESCRIPTION OF INFORMATION TO BE DISCLOSED [ ] OR RECEIVED[ ]

[ ] HEALTH RECORDS LIMITED TO DATES OF SERVICE ______________________

[ ] OFFICE NOTES [ ] LAB RESULTS [ ] XRAY REPORTS [ ] PAP [ ] MAMMOGRAMS

[ ] MEDICATION INFORMATION [ ] EYE EXAMS [ ] IMMUNIZATIONS

[ ] ALL MEDICAL RECORDS **INCLUDING** SUBSTANCE ABUSE, MENTAL HEALTH, AIDS/HIV TREATMENT/DIAGNOSIS

[ ] ALL MEDICAL RECORDS **EXCLUDING** SUBSTANCE ABUSE, MENTAL HEALTH, AIDS/HIV TREATMENT/DIAGNOSIS

REASON FOR DISCLOSURE:

[ ] CHANGING PHYSICIANS TO ______________________

[ ] LEGAL REASONS ______________________

[ ] OTHER ______________________

[ ] INSURANCE/WORKERS COMP

[ ]SECOND OPINION

[ ] PATIENT REQUEST

This information is made at the request of the patient or personal representative. YES NO

If no, please explain: ______________________________

Is this authorization limited to a Single Disclosure/Exchange? YES NO IF NO AUTHORIZATION WILL EXPIRE IN ONE YEAR

This information may be disclosed/exchanged effective: IMMEDIATELY OTHER (specify date) ______________

This authorization [ ] DOES or [ ] DOES NOT extend to information placed in my record after the date I signed this form.

Is there any information you do not want to release? NO YES (specify)______________________

As the person signing this authorization, I acknowledge that I am giving permission to Clinch River Health Services to disclose/exchange PHI. I further acknowledge that:

- I may refuse to sign this authorization.
- Clinch River Health Services will not condition treatment on my signing the authorization.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, by notifying the providing organization in writing. There is a potential for any information disclosed/exchanges pursuant to this authorization to be subject to redisclosure by the recipient and, there, no longer protected by the provisions of the HIPAA Privacy Rule.
- If this information is being disclosed/exchanged from records protected by the Federal Substance Abuse confidentiality rules (42 CFR, Part 2), the Federal rules prohibit the recipient from making any further disclosure/exchange of this information unless further disclosure is expressly permitted by my written authorization or as otherwise permitted by 42 CFR Part 2. A general authorization for this disclosure/release of medical or other information is NOT sufficient for this purpose.
- This information will be shared with those individuals in the criminal justice system who have a need for the information in connection with their duty to monitor my treatment.
- I understand that under Virginia statute I may pay a reasonable cost-based fee that includes the cost of supplies and labor, or postage, there is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

PATIENT SIGNATURE:	DATE:
PARENT/GUARDIAN SIGNATURE:	DATE:

The patient or authorized representative was given a copy of this authorization or may request a copy at any time.