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**.

SEX AT BIRTH ☐ **FEMALE** ☐ **MALE** **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

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

Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White ☐ Middle Eastern or North African ☐ Native Hawaiian or Orth Pacific Islander ☐ Other, please specify _____ ☐ Declined

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. (CRHS) 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 AND PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received and read the CRHS HIPAA Notice of Privacy Practices. I have received a copy of the patient's rights and responsibilities. **INITIALS:** _____

3. CONSENT FOR TREATMENT AND INTEROPERABILITY: I give consent to the staff of CRHS to perform emergency medical treatment, acute or chronic medical treatment, preventive healthcare, behavioral/mental healthcare, and health maintenance care as deemed medically necessary. I give CRHS permission to access my EHR information from other entities, including but not limited to hospitals and other care facilities.

INITIALS: _____

4.TREATMENT: We may use and disclose protected health information (PHI) (including alcohol and drug abuse diagnoses protected by Title 42 of CFR) 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:**_____

5. 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:** _____

6. RX HISTORY: I give CRHS permission to access my Medication History from external databases (like Pharmacies) to better process medications.

INITIALS:_____

7. AI CONSENT: I give CRHS consent to make temporary audio records of my visits with the health care provider at practice. Such recordings(s) will be used by practice for charting and operations purposes using AI technology and may be shared with their business associates for troubleshooting and product improvement purposes. Recording will be destroyed after 7 days. **INITIALS:** _____

8. TELEHEALTH SERVICE if offered: I agree to receive audiovisual medical/behavioral services. **INITIALS:** _____

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

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

Parental Authorization for Minors Seeking Medical Treatment

It is the policy of Clinch River Health Services to comply with state and federal laws that govern the treatment of children under the age of 18. Under this law, it is necessary to have the presence of a parent or legal guardian or a signed document giving consent before evaluation and/or treatment can be rendered to children under the age of 18.

I/We request and authorize Clinch River Health Services and its personnel to provide medical care services to:
Childs Name:_____ Date of Birth:_____

If your child is over the age of 16, do we have your permission to treat them if they come alone to any appointment? YES NO
List any individuals, other than the legal guardians, whom have permission to bring your child in for medical treatment during your absence.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Is there custody/guardianship orders for this minor child? **If YES, please provide a copy of the legal document.** YES NO

_____ _____ _____

Signature of Parent/Legal Guardian Printed Name Relationship

_____ _____

Phone Number: 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 alcoholic beverages? 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	Birth Defects
High Blood Pressure	Arthritis
Diabetes	Thyroid Problems
Overweight	Gout
Stroke	Anemia
Chronic Bronchitis	High Cholesterol
Emphysema	Bleeding Problems
Asthma	Glaucoma
Tuberculosis	Depression
Hepatitis	Anxiety
Ulcer	Suicide Attempt
Kidney Stone	STD
Urinary Infections	Breast Cancer
Seizures	Lung Cancer
Migraines	Colon Cancer
Decreased Vision	Skin Cancer
Decreased Hearing	Other Cancer_____
Black Lung	Amputations_____

FAMILY HISTORY

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

High Blood Pressure	Depression	Diabetes
Psychiatric Illness	Overweight	Alcoholism
High Cholesterol	Heart Attack	Bleeding Disorder
Anemia	Stroke	Glaucoma
Tuberculosis	Lung Cancer	Lung Problems
Breast Cancer	Colon Cancer	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

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Clinch River Health Services

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 of 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 because of therapeutic interventions. I understand that Clinch River Health Services does not guarantee any results or outcomes from the treatment process. In addition, I am aware of the alternative treatment facilities available to me.

Since this is a clinic practice and licensed facility, I recognize the 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 regularly scheduled business hours. I understand the evacuation exits 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 have 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 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 my healthcare provider, which has 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

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 of Patient	Date
_____	_____	
Staff/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
Mikella Maine, FNP
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. **APPLICATIONS WITHOUT INCOME OR INCOME WITHOUT AN APPLICATION WILL BE DESTROYED AFTER 30 DAYS. IF BOTH ARE NOT RECEIVED.**
Telephone:	
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, Allmony					
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

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, 17285 VETERANS MEMORIAL HWY, DUNGANNON VA**
PHONE: 276-467-2201 FAX: 276-467-2673
TO OBTAIN MY MEDICAL/MENTAL/BEHAVORIAL HEALTH INFORMATION 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: [ ] AT REQUEST OF PCP FOR COORDINATION OF CARE
[ ] CHANGING PHYSICIANS TO _____ [ ] INSURANCE/WORKERS COMP
[ ] LEGAL REASONS _____ [ ]SECOND OPINION
[ ] OTHER _____ [ ] 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.