MATTHEW WALKER
Comprehensive Health Center, Inc.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION (PLEASE GIVE YOUR IDENTIFICATION TO THE RECEPTIONIST)			
Patient's Last name: First: MI:			Social Security#
Have you been seen at one of our locations before? ☐ Yes ☐ No	Birth date:	Age:	Sex: ☐ M ☐ F
What is your marital status? ☐ Single ☐ Married ☐ Widower ☐ Divorced ☐ Separated			
Address:			ZIP Code:
Home Phone Number:	Cell Phone Number	Work/Alternate Phone Number	

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home phone no:	Alternate phone no:

DEMOGRAPHIC INFORMATION				
School Based? ❑ Yes ❑ No	Migrant Farm Worker? ❑ Yes ❑ No	Homeless? ❑ Yes ❑ No	Veteran? ❑ Yes ❑ No	Are You Hispanic or Latino? ❑ Yes ❑ No
What is your race? ❑ Asian ❑ African-American ❑ White ❑ American Indian ❑ Native Hawaiian ❑More than one race ❑Refuse to Report				
PREFERRED LANGUAGE: ☐English ☐Spanish ☐Arabic ☐Other:				

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)		
What insurance coverage do you have:	☐**Private Insurance** ☐ **TennCare** ☐**Medicare** ☐**Other**	
Name of Primary Insurance:		
Subscribers Name:	Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other:	
Subscribers Birthdate	Subscribers Social Security Number	
Group Name	Policy Number:	Copayment:
Name of Secondary Insurance:		
Subscribers Name:	Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other:	
Subscribers Birthdate	Subscribers Social Security Number	
Group Name	Policy Number:	Copayment:
Would you like to apply for the Sliding Fee Discount Program? ❑ Yes ❑ No		
Do you have a living will or advanced directive? ❑ Yes ❑ No If you do not have a living will or advanced directive ask our staff for information on this important subject.		

CONSENT TO TREAT

The preceding information is true to the best of my knowledge. I request MWCHC to provide me and/or the patient identified above with medical, behavioral health, dental, and/or diagnostic treatment. I understand that my primary care team is supported by many clinicians, including, but not limited to Collaborating Pharmacists and Behavioral Health professionals. I request and consent to such professionals rendering service to me. I understand that there is no guarantee or assurance as to the results of any treatment provided. I acknowledge my responsibility to pay for this care according to the fees charged by MWCHC. I understand that I will be responsible for fees that are not paid by my insurer or other third party to the extent allowed by law, contract, or applicable policies. I also agree that if I do not have any insurance, I will be responsible for fees charged by MWCHC. I agree that I have been informed of MWCHC's Notice of Privacy Practices and that a copy of such notice is available to me.

Patient/Guardian signature *Date*

MATTHEW WALKER
Comprehensive Health Center, Inc.

I agree to allow Matthew Walker Comprehensive Health Center, Inc. to contact me in the following methods regarding my private health information, evaluation and treatment.

PRIVACY AND COMMUNICATION PREFERENCES		
You may leave messages on my:	☐Cell phone: ☐Home phone: ☐Work phone:	
You may text me information regarding my appointments (reminders/cancellations) on my:	☐Cell phone:	
You may email information about my appointments or other general information to:	Email address:	
I would like to communicate through the Patient Portal	☐Yes ☐No	
You may send information regarding my treatment to:	☐Home address: ☐Work address:	

I authorize Matthew Walker Comprehensive Health Center, Inc. to discuss my healthcare information (which may include history, diagnosis, labs, tests results, treatment and other health information) with the contacts listed below.
I understand that by leaving the space blank I am indicating that I do not want any information released to anyone other than required or permitted by law.

Name:	Relationship:
Phone Number:	Address:
Name:	Relationship:
Phone Number:	Address:

I acknowledge that I have read and consented to the communication provided by this form. I understand the risk associated with the different methods of communication, especially email and texting, and consent to the conditions, restrictions and patient responsibilities. I understand that it is my responsibility to keep my related passwords and access to information confidential.

Patient Name Printed:_____ Date: _____

Patient Signature:_____

MATTHEW WALKER
Comprehensive Health Center, Inc.

Name:	
Address:	
City, State Zip Code:	
Phone	Date of Birth:

It is necessary for us to ask personal questions in order to give you a discount on our services. This information will be kept on file in our Center in strict confidence. You must verify your income at least annually unless you have a significant financial change. **Your yearly income tax return, a W-2 form, payroll checks covering the last 6 weeks or copies of your Social Security checks, or other checks you may receive will be sufficient proof of income.** Your annual income and your family size will be used to calculate your discount.

☐ **I decline to apply for a discount under the Sliding Fee Discount Program**	**Signature:**

What insurance do you have that will cover _____ Initial here if you do NOT have

What is your marital status? Married Widower) Single Divorced Separated

Do you own or rent your home? Own Rent I live with someone

Amount of annual household income?	**You**	**Your Spouse**	**Your Children**	**Other People in Your home**	**Total Family Income**

Place of Employment	**You**	**Your Spouse**	**Your Children**	**Other People in Your home**

How much of your household income is from the following sources?

Sources	**You**	**Your Spouse**	**Your Children**	**Other Persons**	**Total**
Social Security					
Public Assistance					
Retirement Pension					
Rental Income					
Interest Income					
Child Support					
Other:					

How many people live in your home? _____

Name	**Date of Birth**	**Social Security Number**

I declare the above information is true and give Matthew Walker Comprehensive Health Center, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my information should change that I am required to notify the receptionist on my next visit to the clinic.

Signature Date:

Clinic Purpose Only—
Discount Code:

MATTHEW WALKER
Comprehensive Health Center, Inc.

SEXUAL ORIENTATION/SEXUAL IDENTIFICATION FORM

Matthew Walker Comprehensive Health Center is focused on improving the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services. Sexual orientation and gender identity can play a significant role in determining health outcomes. Gaining a better understanding of our communities served, including sexual orientation and gender identity, promotes culturally competent care delivery and contributes to reducing health disparities overall. This information will be kept confidential and used only by your health care team to meet your needs.

Name	
Date of Birth	
What is your current gender identity? (Check ALL that apply)	☐Male ☐Female ☐Transgender Male/Trans Man/FTM ☐Transgender Female/Trans Woman/MTF ☐Gender Queer
What sex were you assigned at birth? (Check ONE)	☐Male ☐Female ☐ Don't know ☐Decline
Do you think of yourself as: (Choose ONE)	☐Lesbian, gay or homosexual ☐Straight or heterosexual ☐Bisexual ☐Something else ☐Don't know ☐Choose not to disclose
How would like to be referred to? (Choose ONE)	☐He ☐She ☐They ☐Ze ☐Sie or Zie
What name do you prefer?	

Patient Signature _____ Date _____

MATTHEW WALKER
Comprehensive Health Center, Inc.

No Call/No Show/Late Policy

Effective, March 6, 2017 you are considered a **No Call/No Show** for not cancelling and/or not showing for an appointment.

You must cancel by a minimum of 4 hours prior to the appointment. For

- **Nashville** you can cancel by calling 615-327-9400.
- **Clarkville** you can cancel by calling 931-920-5000.
- **Smyrna** you can cancel by calling 615-984-4290.

If you are 5 minutes late for your scheduled appointment time, your appointment will be rescheduled or you have the option of being a walk-in.

After 3 No Call/No Show appointments you will not be able to schedule an appointment for 6 months. During the 6 month period you will be able to be seen as a walk-in.

_____ _____

Print Name Patient Date of Birth

_____ _____

Patient Signature Date

This Notice Describes How Medical Information About you May be Used and How You Can Get Access to This Information

Please Review it Carefully

Uses and Disclosures of Health Information

We use health information about you for treatment (diagnostic testing, prescription, etc.) to obtain payment (submit claims and/or encounters to billing services and/or clearinghouses, and/or collection agencies, etc.) for administrative purposes (reporting, utilization management, quality improvement and surveys, etc.) and to evaluate the quality of care that you receive. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information for health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses or disclosures.

We may apply a change to our policies at any time. Before we make a significant change in our polices, we will change our notice and post the new notice in the waiting area and each examination room. You may also request a copy of our notice at any time. For more information about our privacy practices, contact our Corporate Compliance Officer.

Individual Rights: You have the right, following a written request and agreed upon date and time to look at, get a copy of, or receive electronically protected health information about you that we use to make decisions about you. If you request copies we will charge you for each page. The cost to you will not exceed the cost we incur to provide such copies. You also have the right to receive a list of instances where we have disclosed protected health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request in writing that we amend existing information.

You may request in writing that we restrict and/ or not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to agree to it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access or amendment to your records, you may contact our Corporate Compliance Officer who number is listed at the bottom this page. You may send a written complaint to the US Department of Health and Human Services, Office of Civil Rights. The corporate Compliance Manager can provide you with the appropriate address upon request.

Matthew Walker Comprehensive Health Center Legal Duty

We are required by law to protect the privacy of your information, provide notice about our information practices, and follow the information practices that are described in the notice. Questions or complaints may be addressed to:

Matthew Walker Comprehensive Health Center

Corporate Compliance Manager

1035 14th Avenue North

Nashville, TN 37208

If you wish to discuss your complaint or have any questions, you may call the Corporate Compliance Officer at: (615) 327-9400. You will not be penalized in any way for filing a complaint.

HIPAA

Health Insurance Portability Accountability Act

Patient Acknowledgement

I acknowledge that I have received a copy of the Matthew Walker Comprehensive Health Center, Inc. Notice of Privacy Practices as required by HIPAA

I understand that upon completion of reading this notice, any questions I may have may be addressed to our HIPAA Corporate Compliance Officer.

Childs Name If Under 18

Patient Signature/ Responsible Party Signature

Print Name

Date

Matthew Walker Comprehensive Health Center Inc. Use Only Section:

Refusal to sign: Patient has the right to refuse to sign and has decided not to sign.

MWCHC Representative

Date

MATTHEW WALKER
Comprehensive Health Center, Inc.

1035 14th Avenue North

Nashville, TN 37208

615-327-9400

230 Dover Rd,

Clarksville, TN 37042

931-920-5000

739 President PI Ste 100,

Smyrna, TN 37167

615-984-4290

A. Standard: Notice of privacy practices.

1. Right to notice. Except as provided by paragraph (a) (2) or (3) of this section, an individual has a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity and of the individual's rights and the covered entity's legal duties with respect to protected health information.

2. Specific requirements for certain covered health care providers. A cover health care provider that has a direct treatment relationship with an individual must:

❖ Provide the notice no later than the date of the first service delivery, including service delivered electronically to such individual after the compliance date for the covered health care provider.

A. Have the notice available at the service deliver Site for individual to request to take with them; and

B. Post the notice in a clear and prominent location where it is reasonable to expect individuals seeking service from the covered health care provider to be able to read the notice and;

C. Whenever the notice is revised, make the notice available upon request on or after the effective date of the revision and promptly comply with the requirements of paragraph C (2) of this section, if applicable

HIPAA

PRIVACY

STATEMENT