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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | |
| Last Name: | | First Name: | | | | | | | | | | | | Middle: | | | | |
| Parent or Guardians name if patient is a minor: | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | Unit/Apt/Suite/Floor: | | | | | | |
| City: | | | State: | | | | | | | | | | | | Zip Code: | | | |
| Social Security #: | | | Date of Birth: | | | | | | | Email Address (By providing your email address, you agree to receive CHWC updates and notifications): | | | | | | | | |
| Marital Status: Single Married Separated  Divorced Widowed Partner Other:\_\_\_\_\_\_\_\_\_\_\_\_\_  Sexual Orientation: Straight Lesbian/Gay Bisexual  Choose not to disclose Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Gender Identity: Male Female  Trans Male (FTM) Trans Female (MTF)  Genderqueer Choose not to disclose  Other: | | | | | | | | | | |
| Primary Telephone: Home Cell Work  Secondary Telephone: Home Cell Work | | | | | | | | | | | | | | | | | | |
| Race: **Check all that apply** American Indian/Alaskian Native  Black/African American Pacific Islander  Asian Multi-Racial Native American  White Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Ethnicty:    Hispanic/Latino  Non Hispanic/Latino | | | | | | | | | | Language:  English  Spanish  Other:\_\_\_\_\_\_\_\_\_\_\_\_ |
| Homeless:  Yes No Doubled Up  Shelter Transitional Street | Migrant Worker:  Yes  No Seasonal | | | | | | | | Veteran:  Yes  No | | | | Preferred Pharmacy: | | | | | |
| Emergency Contact Name:  Emergency contact can be contacted in the event we are unable to reach you for routine care: | | | | | | | | | | | Phone #: | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | |
| Name of Primary Insurance: | | | | Policy #: | | | | | | | | | | | | Group #: | | |
| Subscriber Name: | | | | | | Patients relationship to subscriber:  Self Spouse Child Other | | | | | | | | | | | | |
| Name of Secondary Insurance: | | | | | Policy #: | | | | | | | | | | | | Group #: | |
| Subscriber Name: | | | | | | | Patients relationship to subscriber:  Self Spouse Child Other | | | | | | | | | | | |
| Please complete the following information to ensure we are able to offer all programs and benefits you may qualify for:  **Family size:\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Household Annual Income: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Fee Schedule 2022 Please choose a Federal Poverty Level based on your family size & income.  **<100% 🞎 101%-133%🞎 134%-167%🞎 168%-200% 🞎**  1 $13,590 $18,075 $22,695 $27,180  2 $18,310 $24,352 $30,578 $36,620  3 $23,030 $30,630 $38,460 $46,060  4 $27,750 $36.908 $46,343 $55,500  5 $32,470 $41,283 $54,225 $64,940  6 $37,190 $49,463 $62,107 $74,380 | | | | | | | | | | | | | | | | | | |

**Medical Authorization – Assignment of Benefits – Notice of Privacy Practices**

I hereby authorize the release of any medical information necessary to process claims for any and all professional services rendered by Community Health & Wellness Center of Greater Torrington, Inc. and any third party establishment necessary to perform business activities. I authorize the payment of any benefits due to Community Health & Wellness Center of Greater Torrington, Inc., and understand any co pays, referrals, new insurance information, deductibles and denied services will be patient’s responsibility. I acknowledge that I have received a copy of Community Health & Wellness Center of Greater Torrington, Inc.’s Notice of Privacy Practices that describes how medical information about me may be used and disclosed. I understand that Community Health & Wellness Center participates in health information exchange to enhance the quality of care provided to me. I acknowledge that I may opt out of information exchange at any time. I authorize Community Health & Wellness Center to access my medical information including diagnostic and screening results from other care providers electronic health record system. I understand that if I have any questions or complaints I may contact the Privacy Officer. I acknowledge I am entitled to updates to these Privacy Practices.

* **I give consent for any type of procedure or treatment by all qualified personnel at CHWCGT, for the above named individual.**
* **I give consent to pull from a database that monitors when and who last prescribed medications to me.**
* **I understand my patient responsibility regarding payment for the services I’ve received and will update new insurance information as needed**
* **As per our policy any services rendered offsite are the responsibility of the patient. CHWCGT will not be responsible for any of these charges. Example: lab, x-rays, specialty care, etc.**
* **I give consent for HIV Testing. I retain the right to opt out of testing at any time.**
* **I have read and understand the Notice of Privacy Practices, including the exchange of my Health Information (HIE)**
* **I have received a copy of my patient rights and responsibilities and understand my rights and responsibilities as a patient.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Guardian/POA/Conservator signature, if applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIPPA given on Date: \_\_\_/\_\_\_\_/\_\_\_\_

**WELCOME TO COMMUNITY HEALTH & WELLNESS CENTER**

The Community Health & Wellness Center is committed to “providing quality, compassionate, and professional health care that is affordable, easily accessible and without discrimination to all residents” of the greater Torrington area. The center provides comprehensive primary and preventive health care regardless of your ability to pay.

**AFTER HOUR COVERAGE**

Any Community Health & Wellness Center patient that has an urgent matter but does not require emergency attention can call 860-489-0931, you will be able to leave a message with our answering service and an on call provider will be contacted immediately. The provider will than contact you ASAP, please be available for a return call!

**FINANCIAL ASSISTANCE**

Everyone deserves quality healthcare! We are a designated Federally Qualified Healthcare Facility who offers a sliding fee schedule for those who qualify. If you feel you are in need of assistance please inquire within, you will be screened by a financial counselor and appropriate steps will be taken to evaluate your financial needs.

***EXCLUDED FROM OUR FINANCIAL ASSISTANCE:***

Services rendered offsite provided by other facilities ex. labs, x-rays, specialty care, etc. These charges are NOT the responsibility of CHWCGT.

**PRESCRIPTION POLICY**

In an effort to better serve our patients, and to manage the large number of medication refill requests that we receive, we ask that our patients help us manage medication refills in the following way:

                -Please remember to inform your Provider and Medical Assistant Team about upcoming medication needs at your appointment. Having your provider refill medications on the day of your appointment will allow you to have uninterrupted access to your medications. This will also help prevent many unnecessary telephone calls.

                -If you run out of medications in between your appointment, please call your pharmacy first. Sometimes patients have remaining refills at their pharmacy. Also, the pharmacy can contact us electronically without the need for a phone call.

                -If you are truly running out of your medications, please contact us at least 5 days in advance so that we can process your refill and prevent you from having to run out completely.

**NO SHOW POLICY**

There is a very high volume of individuals waiting for appointments at our center. Appointments are in great demand.

What makes this situation more difficult is the number of “patients” **who do not keep their scheduled appointments** and do not call in advance to cancel or reschedule an appointment. Due to this, Community Health & Wellness Center is forced to institute a **No Show Policy.**

It is the **Patient’s Responsibility** to notify the office at least 24-48 hours in advance of their scheduled appointment to reschedule or cancel so we may offer the time to another patient waiting to be seen.

**When a patient misses two scheduled appointments, without notifying the office**, the next requested appointment will be stand by (which means no scheduled appointment time will be given and the patient will have to sit and wait for a provider to have an opening in their schedule). **Unfortunately there is no guarantee you will be seen on that day and you may have to return the next day until a provider has an opening in his/her schedule.** In addition, that visit will be brief. We will not delay scheduled patients who show up on time for patients waiting on standby.

By implementing this policy we believe we honor patients who schedule/keep their appointments while accommodating everyone who needs to be seen more efficiently.

**LATE POLICY**

In an effort to provide optimal care for all patients, please arrive on time for appointments. Patients arriving **later than 10 minutes** may be rescheduled with another provider.

**I HAVE READ AND UNDERSTAND THE PRESCRIPTION POLICY, NO SHOW POLICY, AND LATE POLICY AND AS A PATIENT IT IS MY RESPONSIBILITY TO RESPECT THE PATIENT POLICIES OF THE CENTER.**

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PATIENTS SIGNATURE DATE



Patient Grievance Policy

A patient, family member, or caretaker shall have the ability to voice a complaint or grievance to the appropriate levels of authority as a part of the patients right to process and in accordance with CHWC’s Patient Grievance Protocol. Patients, family members, or caretakers voicing complaints and/or grievances shall not be subjected to retaliation or barriers to care.

1. A patient, family member, or caretaker may register a complaint or grievance to any staff member in person, by telephone, mail, or email within 60 calendar days of the date of the event. A Patient Grievance Form will be completed by the staff member upon notification of a patient’s intent to voice a complaint. The staff member will enter the data into CHWC’s Feedback Manager software and attach the Patient Grievance Form.
2. Investigation of a complaint will be conducted as expeditiously as the case requires but no later than 30 calendar days after completion of a Patient Grievance Form. If investigation of a complaint requires additional time, the patient will be notified by telephone that the organization may take up to 14 calendar days to continue its investigation.
3. A patient, family member, or caretaker will be notified by telephone upon completion of the investigation of any action taken based on the evidence uncovered during the investigation. CHWC considers a complaint resolved based on the patient’s verbal expression of satisfaction with actions taken on his or her behalf.
4. If a complaint is not resolved at this point, the Patient Advocate shall tag the complaint as a grievance and forward to the Medical Director for further investigation or review. The Medical Director shall notify the patient in writing of the decision and the evidence on which the decision was based.
5. If the grievance is still unresolved, the patient may request in writing that the Medical Director submit the grievance to the Board of Directors for review. The Board of Directors shall have 30 days from the receipt of the grievance to make a final determination and deliver the response in writing to the Chief Executive Officer, Medical Director, and patient, family or caregiver.
6. The Review Committee will review on a case by case basis any grievance filed by a patient that has been discharged from service at CHWC and is requesting to reinstate services. There must be sufficient evidence to prove the reason for discharge was an isolated incident or the patient has taken appropriate action to minimize the possibility of a repeat of the action that resulted in discharge from services. If the evidence reviewed is satisfactory to the Review Committee, services may be reinstated.
7. Evaluation of the organization in meeting compliance with this policy is assed every two years by the Chief Executive Officer and the Board of Directors. Evaluation includes:
8. A quarterly review of the trends in patient grievance by the Continuous Quality Improvement Committee. The CQI Committee will recommend quality initiatives or system changes based on trending.
9. Quarterly, the Quality Manager will present trended patient grievance data for review by the Medical Director. Any grievance categorized as high priority according to the Patient Grievance Protocol, will be brought to the Medical Director’s attention immediately.
10. A comprehensive bi-annual summary of patient grievance data and trending will go to the Board of Directors for review.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_