

PATIENT INFORMATION				
Last Name:		First Name:		Middle:
Preferred Name:		Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Pronouns:	
Parent or Guardians name if patient is a minor:				
Address:		City:	State:	Zip Code:
Social Security #:		Date of Birth:	Email Address (By providing your email address, you agree to receive CHWC updates and notifications):	
Primary Telephone	Home:	Cell:	Work:	
Secondary Telephone	Home:	Cell:	Work:	
Emergency Contact Name: Emergency contact can be contacted in the event we are unable to reach you for routine care:			Phone #:	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partner <input type="checkbox"/> Other:			Gender Identity <input type="checkbox"/> Trans female (MTF) <input type="checkbox"/> Trans male (FTM) <input type="checkbox"/> Male <input type="checkbox"/> Genderqueer <input type="checkbox"/> Gender nonconforming <input type="checkbox"/> Female <input type="checkbox"/> Gender fluid <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other:	
Sexual Orientation <input type="checkbox"/> Straight <input type="checkbox"/> Lesbian/Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Chose not to disclose <input type="checkbox"/> Other:				
Race: Circle all that apply <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Do not identify <input type="checkbox"/> Other:		Ethnicity: Circle all that apply <input type="checkbox"/> Guatemalan <input type="checkbox"/> Mexican <input type="checkbox"/> Dominican <input type="checkbox"/> Venezuelan <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Not Hispanic / Latino <input type="checkbox"/> Other / Hispanic:		Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
Is there anything else you'd like us to know about you (such as cultural or religious beliefs) concerning your medical treatment?				
I would like help with: Circle all the apply				
<input type="checkbox"/> Food <input type="checkbox"/> Other:		<input type="checkbox"/> None <input type="checkbox"/> Housing		<input type="checkbox"/> Choose not to share <input type="checkbox"/> Transportation
Living situation: <input type="checkbox"/> I have a steady place to live <input type="checkbox"/> I have a place to live today, but I am worried about losing it in the future <input type="checkbox"/> I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)			Migrant Worker: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Seasonal	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No

Please turn over, read and sign

INSURANCE INFORMATION

Name of Primary Insurance:	Policy #:	Group #:
Subscriber Name:		Patients relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Name of Secondary Insurance:	Policy #:	Group #:
Subscriber Name:		Patients relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Preferred Pharmacy (Name, town, address):		

Please complete the following information. We use this to offer you all programs and benefits you may qualify for.

Family size: _____ **Total Household Annual Income: \$** _____

Fee Schedule 2024 Please choose a Federal Poverty Level based on your family size & income.

	<100% <input type="checkbox"/>	101%-133% <input type="checkbox"/>	134%-167% <input type="checkbox"/>	168%-200% <input type="checkbox"/>
1	\$15,060	\$20,030	\$25,150	\$30,120
2	\$20,440	\$27,185	\$34,135	\$40,880
3	\$25,820	\$34,341	\$43,119	\$51,640
4	\$31,200	\$41,496	\$52,104	\$62,400
5	\$36,580	\$48,651	\$61,089	\$73,160
6	\$41,960	\$55,807	\$70,073	\$83,920



Authorization to Treat – Assignment of Benefits – Notice of Privacy Practices

- I hereby consent to being treated as a patient of Community Health & Wellness Center of Greater Torrington, Inc. (CHWCGT) at any CHWCGT location, including school-based locations when applicable, for the purpose of receiving medical, behavioral health or dental care and treatment and/or diagnostic procedures. I understand I have the right to consent or refuse to consent to any proposed procedure or therapeutic treatment, and that a discussion of the risks, benefits and alternatives to each procedure or treatment will be available to me prior to each procedure or treatment.
- I hereby authorize the release of any medical information necessary to process claims for any and all professional services rendered by CHWCGT and any third-party establishment necessary to perform business activities.
- I hereby authorize and direct my insurance carrier to make the payment of any benefits due directly to CHWCGT, and I understand any co pays, referrals, new insurance information, deductibles and denied services will be patient’s responsibility as applicable. Copays will not be collected in our school-based programs.
- I understand my patient responsibility regarding payment for the services I receive from CHWCGT and agree to provide new or updated insurance information as needed.
- CHWCGT is not responsible for any services I may receive at other facilities, which are not owned and operated by CHWCGT. Any charges from such facilities are the responsibility of the patient. For example: lab, x-rays, specialty care, etc.
- I acknowledge that I have received a copy of CHWCGT Notice of Privacy Practices that describes how medical information about me may be used and disclosed. I understand that I am entitled to updates to these Privacy Practices, and if I have any questions or complaints, I may contact the CHWCGT Privacy Officer.
- I understand CHWCGT may access my medical information, including diagnostic and screening results, from other care providers’ electronic health record systems in order to provide treatment.
- I hereby consent to allow CHWCGT to retrieve information from a database that monitors when and who last prescribed medications to me.
- I understand that CHWCGT 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.
- As required by law, CHWCGT will share immunization information with the State of CT Department of Public Health (DPH). I understand I can opt out of this by sending a signed written request to the DPH Immunization Program.
- Adolescents, while encouraged to communicate with their parents, can receive confidential services for Sexually Transmitted Disease Testing and Treatment, Pregnancy Testing, Family Planning Counseling and Referral, and Substance Abuse Counseling and Referral at our 469 Migeon Avenue location in Torrington and at our 10 Center Street location in Winsted. I understand an adolescent may choose to receive confidential services. I understand that information regarding the above conditions will be shared with the adolescent’s legal guardian if the adolescent agrees or when there is a serious health risk that requires reporting by State or Federal law.
- If I am 18 years of age or older, I give consent for HIV Testing and understand that I retain the right to opt out of testing at any time.
- I have received a copy of my patient rights and responsibilities and understand my rights and responsibilities as a patient.

Patient Printed Name: _____ Birthday: ____/____/____

Patient Signature: _____ Date: ____/____/____

Guardian/POA/Conservator /Parent signature, if applicable

HIPAA given on 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.

- A. 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.
- B. 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.
- C. 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.
- D. 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.
- E. 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.
- F. 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.
- G. Evaluation of the organization in meeting compliance with this policy is assessed every two years by the Chief Executive Officer and the Board of Directors. Evaluation includes:
 - a) 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.
 - b) 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.
 - c) 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: _____

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.

HOURS OF OPERATION:

Torrington Location: Monday, Tuesday, Wednesday, Friday 8:30 am-5:00 pm, Thursday 8:30 am- 8:00 pm
Winsted Location- Monday thru Friday 8:30 am- 5:00 pm

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 then 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.

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.

PATIENTS SIGNATURE

DATE