SOUTHWEST VIRGINIA
COMMUNITY HEALTH SYSTEMS

Tazewell Community Health Center
386 Ben Bolt Avenue
Tazewell, VA 24651
Phone: (276) 979-9899
Fax: (276) 979-9798

# Welcome!

We would like to take this opportunity to welcome you to our organization. We want to thank you for trusting us to be your primary medical care provider. Our mission is to provide care for all of your health needs. We provide care using a holistic approach for prevention and treatment. All of our services are integrated to provide you with the best possible outcomes.

Southwest Virginia Community Health Systems, Inc. provides services in Saltville, Tazewell, Meadowview and Bristol VA/TN areas. The services offered are primary medical, dental, vision, addiction recovery, and behavioral health. Please visit our website, svchs.com, for more detailed information about our services and locations.

Enclosed with this communication are the forms that you need to bring to your first visit. It is very important that you bring your Insurance information and a picture identification card, as well. (A driver's license is preferred).

If you have questions relating to your visit, please feel free to contact our staff at 276-496-4492.

Respectfully yours,
Bryan Haynes, Executive Director

Thank you for choosing Southwest Virginia Community Health Systems, Inc. to handle your healthcare needs.

Please take a few minutes to review and complete the Patient Demographics form as well as the General Consent form.

If you need a slide fee application or would like to review our Privacy policy, they are available on our website www.svchs.com.

Please remember to bring these forms with you to your first visit. We look forward to serving you in the future.

## Patient Rights

This health center was created to serve the needs of your community. We want you to be an active part of your treatment here.

- We want you to know what you can expect from us. We want you to be informed about our policies regarding confidentiality, treatment of minors, and other ethical issues. There are some situations, however, when the law itself determines what we must do.
- We want you to know your rights as a patient of this center and to exercise them. A patient who participates in his or her care helps to create a successful outcome.
- You have a right to a reasonable response to your requests for treatment within the scope of the health center's mission, capacity, and regulations.
- You have a right to considerate and respectful care.
- You have a right to confidential treatment. You also have the right to approve or disapprove the release of any disclosures or records, except when release is required by law.
- You have a right to information about your diagnosis, treatments, and prognosis. This information will help you to make informed decisions regarding your care,
- You have the right to prompt and effective pain management and to be informed by staff about available measures.
- You have the right to access any information contained in your medical record.
- You have the right and responsibility to participate in decisions about the intensity and scope of your treatment, within the limits of the health center's mission and applicable laws.
- You have the right to care which takes into consideration your psychosocial, spiritual, and cultural values.
- You have the right to accept medical care, or to refuse treatment, to the extent permitted by law. You also have the right to be informed of the medical consequences of refusing treatment.
- You have the right to participate in the consideration of ethical issues that arise in your care.
- You guardian, next of kin, or legally authorized responsible person can exercise your rights for you if you have been medically or legally determined to be unable to participate yourself.
- You have the right to be informed of any research or experimentation which could affect your care. You may then decide whether or not you want to participate in it.
- You have the right to be made aware of advanced directives and to know how this organization will respond to such advance directives.

This Information about patient rights can be found m: The Joint Commission's Comprehensive Accreditation Manual for Ambulatory Care, 2000.

# PATIENT "NO SHOW" POLICY SUMMARY

Our patients are strongly urged to keep their appointments. If you cannot make your appointment, please be sure to call as soon as possible when you know you will not be able to come for your visit. **"No show" patients (those who don't call & cancel/reschedule, without at least an 2 hour notice or simply do not show up for a scheduled appointment)**, cause us to hold appointments that would otherwise be used by someone who is ill and may need to be seen by a provider.

**SVCHS, Inc.'s** policy regarding "no shows" is as follows:

1. **First "no show" occurrence** – Our staff will call to find out the reason for missing your visit and offer to make another appointment for you.
2. **Second "no show" occurrence** – You will receive a letter from our staff warning you of the consequences of not presenting for your visit.
3. **Third "no show" occurrence** – will constitute a "non-compliance issue" which will be discussed with your Care Team. The Care Team determines the severity of the action and determines the outcome. The third "no show" could result in a patient dismissal or necessitate a "Cancellation Status" for the patient. "Cancellation Status" means that if a patient needs to be seen by our providers, they must contact the office after 10:00 a.m. to check for the next available appointment.
4. If you are more than 10 minutes late for your appointment, you will be considered a "no show" and will have to reschedule your appointment for another day.

As partners in your care, we respect and acknowledge the confidence you show in our organization by allowing us to participate in your care. By the same token we ask that you respect us and accept responsibility for keeping your appointments as scheduled.

**We look forward to a long and rewarding provider/patient relationship and welcome you to our facility.**

**Thank you & Welcome!**

## *General Consent*

Name: _____ DOB:_____ SSN:_____

1. CONSENT TO FILE INSURANCE/CORRECT INFORMATION
   I authorize the release of any and all medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I authorize SVCHS to file my insurance for services rendered. I request that payment be made directly to SVCHS. I certify that the information that I have reported with regard to my insurance coverage and my personal information is correct. I understand that I am responsible for any and all balances that my insurance company does not pay. I understand that claims may be filed electronically through a safety net Internet portal. I understand that I am responsible for all charges incurred regardless of my insurance status or lack thereof. I also understand that I am, as a patient, required to abide by the policies of SVCHS, Inc.
2. HIPPA NOTICE OF PRIVACY POLICY
   I acknowledge that I have received and or have read SVCHS's HIPPA Notice of Privacy Policy.
3. CONSENT FOR TREATMENT
   I give my consent to the medical staff of SVCHS to perform emergency medical treatment, acute or chronic medical treatment, preventive health care, behavioral/mental health care, and health maintenance care as deemed medically necessary. (If the above named individual is a minor at the time of consent, a parent or legal guardian must sign this consent for treatment.) A "Behavioral Health Consultant" is a member of the primary care team that works closely with your medical provider to recognize and address medical conditions associated with acute and chronic mental and emotional disordered conditions. There is only one electronic health record used between primary care team members in addressing your treatment plan of care and this health information is shared between these primary care team members.
4. SVCHS is serious about the responsibility of keeping your medical and account information private and confidential. In order for us to share any of your information with someone else, you must designate who you want to have access to this information and give us your signed permission to share the information.

a. If we are unable to get in touch with you or someone calls the office about you, please list family members or others we may notify concerning your general medical condition, lab results, test results, other treatment results, or appointment information. If you do not list anyone, then we will not share your private information with anyone else.

Name _____ Relationship _____ Phone# _____ Date _____

Name _____ Relationship _____ Phone# _____ Date _____

b. If you wish to designate someone else to receive information concerning your account and balance information, please list below.

Name _____ Relationship _____ Phone# _____ Date _____

Name _____ Relationship _____ Phone# _____ Date _____

c. If we are unable to contact you and you have an answering machine, do we have your permission to leave a message?

Yes _____ No _____

5. DATA PARTICIPANT may make your medical information available electronically, or may electronically transmit your medical information to a third party, in order to fulfill Data Participant's obligations to release your medical information to others in the future.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE_____

WITNESS SIGNATURE _____ DATE_____

(THIS CONSENT FORM WILL BE USED AS NEEDED. YOU MAY REVOKE OR CHANGE ANY OF THE ABOVE CONSENTS AT ANYTIME.)

Interpreter (if necessary)_____

Date:_____

**2021 Consent Revised**

## ADULT PATIENT DEMOGRAPHIC FORM

**PERSONAL INFORMATION:**

NAME: _____

First Middle Last

PREFERRED NAME:_____

ADDRESS:_____
PO BOX PHYSICAL ADDRESS/STREET ADDRESS

_____
CITY STATE ZIP

TELEPHONE: HOME_____

CELL_____OTHER_____

EMAIL ADDRESS:_____

DATE OF BIRTH:_____ _____ SEX: Male_____ Female_____

MARITAL STATUS: Single_____ Married_____ Divorced_____ Other_____

SOCIAL SECURITY NUMBER: _____

STUDENT: Full -Time___ Part -Time___ No___

RACE: American Indian or Alaskan Native _____ Asian _____ Black or African American _____
Native Hawaiian or other Pacific Islander _____ White _____ Refused to respond _____

ETHNICITY: Hispanic _____ Non-Hispanic _____ Refused to respond _____

**RESPONSIBLE PERSON FOR PAYMENT:**
NAME:_____ PHONE:_____

ADDRESS:_____

RELATIONSHIP TO PATIENT:_____

HOMELESS? YES____ NO____ IN TRANSITION? YES____ NO____

**EMPLOYMENT INFORMATION:**
EMPLOYER NAME:_____
EMPLOYER ADDRESS:_____
EMPLOYER PHONE NUMBER:_____
EMPLOYMENT STATUS: Full-time_____ Part-time_____ Unemployed_____

**FINANCIAL INFORMATION - RANGE OF INCOME PER YEAR:** ____# in household (including yourself)

_____ I prefer not to give this information

| | | |
|---|---|---|
| _____ $0 - $5,000 | _____ $5,001 - $10,000 | _____ $10,001 - $15,000 |
| _____ $15,001 - $20,000 | _____ $20,001 - $25,000 | _____ $25,001 - $30,000 |
| _____ $30,001 - $35,000 | _____ $35,001 - $40,000 | _____ $40,001 - $45,000 |
| _____ $45,001 - $50,000 | _____ $50,001 - $55,000 | _____ $55,001 - $60,000 |
| _____ $65,001 - $70,000 | _____ $70,001 - $75,000 | _____ $75,001 or higher |

Do you feel financially strained? YES_____ NO_____

**EMERGENCY CONTACT:**

NAME:_____

ADDRESS:_____

TELEPHONE NUMBER:_____

RELATIONSHIP TO PATIENT: _____

**INSURANCE INFORMATION:**

INSURANCE NAME:_____

SUBSCRIBER NAME:_____

SUBSCRIBER ID# _____

GROUP # _____ EFF. DATE_____

INSURANCE PROVIDED BY EMPLOYER? Yes_____No_____

IS PATIENT COVERED BY INSURANCE? Yes_____No_____

PATIENT RELATIONSHIP TO SUBSCRIBER: _____

SECONDARY INSURANCE (if applicable)_____

SUBSCRIBER NAME:_____ ID#_____

GROUP #_____ EFF. DATE_____

*****IMPORTANT*****

**PHARMACY**_____ PHONE_____

ADDRESS_____

Translator or interpreter required?:_____Yes _____No_____

Patient (or)
Guardian Signature_____ Date:_____

Please check one:

| | **PATIENT'S SEXUAL ORIENTATION** | | **PATIENT'S GENDER IDENTITY** |
|---|---|---|---|
| | | | |
| | Lesbian or Gay | | Male |
| | Straight (not Lesbian or Gay) | | Female |
| | Bisexual | | Transgender Male/Female to Male |
| | Something else | | Transgender Female/Male-to-Female |
| | Don't know | | Genderqueer (neither exclusively male or female) |
| | Choose not to disclose | | Other |
| | | | Choose not to disclose |
| | | | |

Note:

Collection of this information is a requirement for Community Health Centers in reporting to our Federal granting agency. No names will be attached to collection of this data, only the numbers will be reported.

If you do not wish to answer, please use the "Choose not to disclose" option which is the last option on the chart.

Thank you for your cooperation,

Southwest Virginia Community Health Systems, Inc.

# MEDICAL HISTORY

## NEW PATIENT INFORMATION

| Last Name | | First | | M.I. | DOB | |
|---|---|---|---|---|---|---|
| Previous or Current Primary Care Physician: | | | | | | |
| Primary Care Physician Phone: | | | | | | |
| Date of last physical exam: | | | | | | |

## PLEASE LIST ANY OTHER PHYSICIANS THAT CONTRIBUTE TO YOUR HEALTH CARE

| NAME | CONTACT NUMBER | SPECIALTY | DATE OF LAST VISIT |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## CURRENT MEDICAL PROBLEMS

*Please list any concerns or problems you would like to address with your physician:*

## MEDICATIONS

Provide Your Local Pharmacy Name and Phone:

*List your prescribed and over-the-counter medications (i.e., vitamins, aspirin, inhalers)*

| Medication | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## MEDICAL HISTORY

*Current and past medical diagnosis (check all that apply)*

| | | | | |
|---|---|---|---|---|
| ☐ High Blood Pressure | ☐ Kidney stones | ☐ HIV/AIDS | ☐ Insomnia | ☐ Hypogonadism |
| ☐ Diabetes | ☐ Enlarged prostate | ☐ Hepatitis C | ☐ Depression | ☐ Bladder Cancer |
| ☐ High cholesterol | ☐ Urinary incontinence | ☐ Cirrhosis | ☐ Osteoporosis | ☐ Kidney Cancer |
| ☐ Heart disease | ☐ Chronic pain | ☐ Stomach ulcer | ☐ Osteopenia | ☐ Prostate Cancer |
| ☐ Heart attack | ☐ Arthritis, degenerative | ☐ GERD/reflux | ☐ Congestive heart | ☐ Cancer (specify) |
| ☐ Abnormal heart valve | ☐ Arthritis, rheumatoid | ☐ Irritable bowel | ☐ Crohn's disease | ☐ Cancer (specify) |
| ☐ Heart failure | ☐ Arthritis, gout | ☐ Seizures | ☐ Ulcerative Colitis | ☐ Cancer (specify) |
| ☐ Stroke | ☐ COPD | ☐ Migraine headaches | ☐ UTI | ☐ Other (specify) |
| ☐ Kidney disease | ☐ Asthma | ☐ Sleep apnea | ☐ Erectile dysfunction | ☐ Other (specify) |
| ☐ Thyroid problems | ☐ Glaucoma | ☐ Anxiety | ☐ Currently pregnant?<br>Estimated delivery date: | ☐ Previous pregnancies<br># _____ times |
| ☐ Blood clots, legs | ☐ Blood clots, lungs | Exposure to: ☐ Asbestos ☐ Chemicals ☐ Ionizing Radiation | | |

## ALLERGIES TO MEDICATIONS

Check here if you have no known allergies ☐

| Medication | Reaction You Had |
|---|---|
| | |
| | |
| | |
| | |

## IMMUNIZATIONS AND DATES

*If checked, please provide date(s)*

| | | |
|---|---|---|
| ☐ Influenza | ☐ Hepatitis B | ☐ MMR (measles, mumps, rubella) |
| ☐ Pneumonia | ☐ Shingles/Zoster | ☐ Tdap (tetanus, diphtheria, pertussis) |

## HEALTH SCREENINGS TESTS

| | | | |
|---|---|---|---|
| Mammogram | ☐ Normal ☐ Abnormal | Date: | Provider: |

| | | | |
|---|---|---|---|
| Colonoscopy | ☐ Normal ☐ Abnormal | Date: | Provider: |
| Fecal occult blood | ☐ Normal ☐ Abnormal | Date: | Provider: |
| Pap smear | ☐ Normal ☐ Abnormal | Date: | Provider: |
| Bone density (DEXA) | ☐ Normal ☐ Abnormal | Date: | Provider: |
| Eye exam | ☐ Normal ☐ Abnormal | Date: | Provider: |

## SURGICAL HISTORY

| Operation | Year | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## PAST HOSPITALIZATIONS

| Reason | Year | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## FAMILY HISTORY

| Relative | Current Age or Age at Time of Death | Heart Attack | Stroke | Cancer | Other Health Problems |
|---|---|---|---|---|---|
| Mother ☐ Living ☐ Deceased | | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>Type:_____ | |
| Father ☐ Living ☐ Deceased | | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>Type:_____ | |

| | | | | | |
|---|---|---|---|---|---|
| Sibling ☐ Living ☐ Deceased | | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>Type:_____ | |
| Sibling ☐ Living ☐ Deceased | | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>Type:_____ | |
| Sibling ☐ Living ☐ Deceased | | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>Type:_____ | |
| Grandmother: Maternal<br>☐ Living ☐ Deceased | | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>Type:_____ | |
| Grandfather: Maternal<br>☐ Living ☐ Deceased | | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>Type:_____ | |
| Grandmother: Paternal<br>☐ Living ☐ Deceased | | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>Type:_____ | |
| Grandfather: Paternal<br>☐ Living ☐ Deceased | | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>At age:_____ | ☐ No ☐ Yes<br>Type:_____ | |

## SOCIAL HISTORY

| | | |
|---|---|---|
| Place of Birth: | | |
| Occupation: | | Travel outside of USA: ☐ No ☐ Yes |
| What is your highest education: ☐ High School ☐ Some college ☐ College graduate ☐ Advanced degree | | |
| Marital Status: ☐ Single ☐ Partnered/Significant Other ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | | |
| **Alcohol** | Do you drink alcohol? | ☐ No ☐ Yes |
| | If yes, what kind? | |
| | How many drinks per week? | |
| | Are you concerned about the amount you drink? | ☐ No ☐ Yes |
| **Tobacco** | Do you use tobacco? | ☐ No ☐ Yes |
| | ☐ Cigarettes _____pks/day ☐ Chew _____#/day ☐ Pipe _____#/day ☐ Cigars _____#/day ☐ E-cigarettes/vaping _____#/day | |

| | | |
|---|---|---|
| | Number of years used: Year quit: | |
| **Sex** | How many sexual partners have you had in the past six months? | |
| | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness or other sexual transmitted diseases? | ☐ No ☐ Yes |
| **Personal Safety** | Do you live alone? | ☐ No ☐ Yes |
| | Do you have frequent falls? | ☐ No ☐ Yes |
| | Do you have vison or hearing loss? | ☐ No ☐ Yes |
| | Do you have an Advance Directive or Living Will? | ☐ No ☐ Yes |
| | Would you like information on creation of these? | ☐ No ☐ Yes |
| **Depression** | In the past two weeks have you felt down, depressed or hopeless? | ☐ No ☐ Yes |
| | In the past two weeks have you felt little interest or pleasure in doing things? | ☐ No ☐ Yes |
| **Anxiety** | In the past two weeks have you been feeling nervous, anxious, or on edge? | ☐ No ☐ Yes |
| | If yes the how frequently: ☐ Several Days ☐ More than half the days ☐ Nearly every day | |
| | In the past two weeks have you not been able to stop or control worrying? | ☐ No ☐ Yes |
| | If yes the how frequently: ☐ Several Days ☐ More than half the days ☐ Nearly every day | |
| **Exercise** | ☐ Sedentary (No exercise) | |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | |
| | ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes) | |
| | ☐ Regular vigorous exercise (i.e., work or recreation, 4x/week for 30 minutes) | |
| **Domestic** | Over the last 12 months, has anyone close to you hurt, hit or threatened you? | ☐ No ☐ Yes |
| **Drugs** | Do you currently use recreational or illicit drugs? | ☐ No ☐ Yes |
| | Have you ever given yourself street drugs with a needle? | ☐ No ☐ Yes |

# Permission for Telehealth Visits

**What is telehealth?**

Telehealth is a way to visit with healthcare providers, such as your doctor, nurse practitioner, or dentist.

You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

**How do I use telehealth?**

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

**How does telehealth help me?**

- You don't have to go to a clinic or hospital to **see** your provider.
- You won't risk getting sick from other people.

**Can telehealth be bad for me?**

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

**Will my telehealth visit be private?**

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

**What if I try telehealth and don't like it?**

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit.
- If you decide you do not want to use telehealth again:
    - call 276-496-4433 chose your clinic site and say you want to stop

- It will be as if you never signed this form.

**How much does a telehealth visit cost?**

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit for a medical visit. A teledentistry visit could cost more than an in person visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

**Do I have to sign this document?**

No. Only sign this document if you want to use telehealth.

**What does it mean if I sign this document?**

If you sign this document, you agree that:

- We answered all your questions.
- You want a telehealth visit.

If you sign this document, we will give you a copy.

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Your name (please print) Date

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Your signature Date