COPLIN
HEALTH SYSTEMS
www.coplinhealthsystems.com

Patient Registration Form

Personal Information **Patient Number:**

Social Security #:	**First Name:**	**Mid. Initial:**
Last Name:	**Preferred Name:**	**Suffix:**
Date of Birth:	**Employer Name:**	
Gender: ☐Male ☐Female ☐Transgender M to F ☐Transgender F to M		
Marital Status: ☐ Single ☐Married ☐Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown		
Employment Status: ☐ Employed ☐Retired ☐Disabled ☐Student: ☐FT ☐PT		
Mailing Address: **Apt/Suite #:**	**Zip:**	**County:**
City:	**State:**	**Country:** **USA**
Email: **Would you like to receive text and/or email reminders of your appointment:** ☐**Yes** ☐ **No**	**Home Phone #:** **Work Phone #:**	**Cell Phone #:** **Preferred Phone:**
Preferred Method of Contact: ☐**Home** ☐**Work** ☐**Cell** ☐**Voice** ☐**Email** ☐ **Text** ☐**Don't Contact**	**Preferred Provider (What provider do you want to see?):**	
Patient is Minor: ☐ **Yes** ☐**No**	*As a Federally Qualified Health Center, we are required to collect the following information.*	

Coplin Health systems is asking you to self-identify your ethnicity, race, disability, and veteran status. No negative or adverse action will be taken, regardless of whether you provide this information. **Participation in the survey is voluntary.** However, your cooperation and participation will allow us to serve our communities better and obtain the most accurate data possible for reporting purposes. No patient will be discriminated against because of race, gender, color, natural origin, age, disability, or religion.

Please select a sexual orientation:

☐Straight/heterosexual ☐Lesbian, Gay, or homosexual ☐Bisexual ☐Other

Please Select one or more races that you identify with from the following:

☐Caucasian ☐Black/African American ☐Hispanic/Latino ☐American Indian/Alaskan native

☐Native Hawaiian/Other Pacific Islander ☐Asian ☐American Indian/Alaskan native ☐Other__________________

Language: ☐ English ☐Other (please specify what other language is your primary ________________________)

Patient Registration Form

Income Information *As a nonprofit organization, we are required to collect the following information. It is used for grant purposes only. (Please Check)*

Number of People Currently Living in your Household:	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Estimated Monthly Household Income:	☐$100-500 ☐$500-1,000 ☐$1,001-1,500 ☐$1,501-2,000 ☐$2,001-2,500 ☐$2,501-3,000 ☐$3,001-3,500 ☐$3,501-4,000 ☐$4,001-4,500 ☐$4,501-5,000 ☐$5,001-5,500 ☐$5,501-6,000
Household Status:	☐Own my home ☐Rent ☐Live with someone ☐In shelter
Military Status:	☐Not a Veteran ☐Active Service ☐Veteran
Disability Status: Do you have a disability as identified by the American with Disabilities Act?	☐Yes ☐No

Insurance Information (Our staff will fill this information out for you if you give them your insurance card)

Primary Health Insurance Name:	**Policy Holder:**	**Group Number:**
Policy Holder Date of Birth:	**Primary Policy Holder ID:**	
Place of Employment:	**Policy Holder Social Security Number:**	

Secondary Health Insurance Name:	**Policy Holder:**	**Group Number:**
Policy Holder Date of Birth	**Secondary Policy Holder ID:**	
Place of Employment:	**Secondary Policy Holder Social Security Number:**	

Emergency Contact

Name:	**Relationship:**	**Home Phone:**
		Cell/Work Phone:

Parent or Legal Guardian ***(If Under 18 Years Old)***

Name:	**Relationship:**	**Home Phone:**
		Cell/Work Phone:
Address:	**City:**	**State:**
Zip:	**Home Phone:**	**Cell/Work Phone:**

Financial Responsibility/Guarantor ***(If Different Than Patient)***

Name:		**Address:**	**City:**
State:	**Zip:**	**Home Phone:**	**Cell/Work Phone:**

Pharmacy (Our staff will fill this information out for you if you give them your Prescription card)

Primary Pharmacy:	**Location:**	**Phone Number:**
Secondary Pharmacy:	**Location:**	**Phone Number:**

Please Provide the receptionist with your prescription card for photocopying if it is not included with your insurance card.	*As a Patient You Have Access to CHS Pharmacies across the Organization (River Valley, Ripley & Parkersburg Family Care)*

Medical and Nursing Students

I agree to have nursing or medical students present during my care (Please Check One): ☐Yes ☐No

Acknowledgment:

The above information is true to the best of my knowledge. I understand I am consenting to medical treatment for myself and/or the patient I am responsible for as listed above. I understand that I am financially responsible for any balance. I also authorize Coplin Health Systems or my insurance company to release any information required to process my claims. I understand there will be a $25.00 fee for all returned checks.

Patient or Legal Guardian (Please Print): ____

Patient or Legal Guardian (Signature): ____ Date: ___________________

No Show Policy

The purpose of this policy is to reduce the number of ‘No Show’ patient appointments thereby optimizing provider scheduling and availability. This policy does not apply to children 17 and under, patients with intellectual and developmental disabilities (IDD), patients with traumatic brain injuries (TBI), and/or behavioral health appointments (BH).

A patient will be considered a ‘No Show’ when the patient doesn’t contact the office to cancel a scheduled appointment within 2 hours of the scheduled appointment or the patient doesn’t show for their scheduled medical appointment without notifying Coplin Health Systems.

First ‘No Show’ Appointment: A Care Manager will attempt to contact patient by phone to determine the patient’s no show status within 48 hours of ‘No Show’ appointment. If patient can’t be reached a letter will be sent. The Care Manager will attempt to rectify issues that may have led to the patient no showing. The appointment will be rescheduled if the patient desires the Care Manager to do so. If not, the Care Manager will follow CHS procedure on dismissing a ‘No Show’ patient that chose to not reschedule missed appointment.

Second ‘No Show’ Appointment: The Care Manager will send a 2nd ‘No Show’ letter to patient instructing them to contact the office to reschedule the missed appointment.

Third ‘No Show’ Appointment: If the patient has 3 ‘No Show’ appointments within 1 calendar year it will result in the patient being dismissed permanently from Coplin Health Systems.

The patient, the patient’s guardian or legal representative has the right to file an appeal to the ‘No Show’ status on the respective account. Patients who have been dismissed for ‘No Show’ still may be seen for Acute Care, Emergency or Behavioral Health Services.

I ________________________________ understand that failing to notify CHS of my inability to keep an appointment 3 times in a single calendar year will result in my dismissal from receiving services at any Coplin Health Systems locations. If I believe there is a just cause/reason for my most recent missed appointment, I understand that I can appeal the ‘No Show’ status by writing an appeal to the Office Manager at my healthcare site. Within 7 working days, I will then be informed of the decision of the ‘No Show’ Appeals Committee.

____________________________________ ___________________________ _______________

Patient’s Name Printed Patient’s Signature Date