SCH
Shenandoah
Community Health®

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME / INITIAL	PREVIOUS NAME / PREFERRED NAME

SOCIAL SECURITY #	BIRTHDATE (MM/DD/YYYY)	EMAIL ADDRESS

While Shenandoah Community Health recognizes a number of gender sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different, please let us know.

BIRTH SEX (Circle One)	CURRENT GENDER (Circle One)	PREFERRED PRONOUN (Circle One)
Male Female	Male Female	He, Him, His She, Her, Hers They, Them, Theirs Other
Undifferentiated Unknown	Undifferentiated	Ze, Hir (Gender Free) Asked but unknown Decline to Answer

GENDER IDENTITY	SEXUAL ORIENTATION
☐ Male ☐ Transgender Male/Female-to-Male ☐ Other	☐ Lesbian or Gay ☐ Don't Know
☐ Female ☐ Transgender Female/Male-to-Female	☐ Straight (not lesbian or gay) ☐ Choose not to disclose
☐ Non-binary ☐ Choose not to disclose	☐ Bisexual ☐ Something else, please describe _____

PHYSICAL ADDRESS	CITY, STATE, ZIP	PHONE NUMBER

BILLING ADDRESS (If Different Than Above)	CITY, STATE, ZIP	PREFERRED CONTACT METHOD

MARITAL STATUS (Circle One)	PRIMARY LANGUAGE (Circle One)
Single Married Widowed	English Spanish American Sign Language Creole Haitian Creole
Divorced Legally Separated	Other:_____

EMERGENCY CONTACT NAME	TELEPHONE	RELATIONSHIP

PREFERRED PHARMACY	PRIMARY CARE PROVIDER

HOUSING STATUS	RACE
☐ Not Homeless ☐ Doubling Up	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian
☐ Transitional ☐ Shelter	☐ Other Pacific Islander ☐ White ☐ Other: _____
☐ Street	

MIGRANT WORKER STATUS	ETHNICITY
☐ Migrant ☐ Seasonal	☐ Not Hispanic Or Latino ☐ Hispanic Or Latino

LANGAUGE BARRIER (Circle One)	ARE YOU A MILITARY SERVICE VETERAN? (Circle One)
YES NO	YES NO

CHIEF COMPLAINT/REASON FOR VISIT

REFERRAL SOURCE

Over

HOUSEHOLD SIZE AND ANNUAL FAMILY INCOME	
FAMILY SIZE: _____	**ANNUAL FAMILY INCOME: $_____**

We are required by funding agencies to obtain the following information from our patients for statistical purposes. This will help us secure grants to support outreach and programs for patients with special needs. Your individual information remains private and confidential and is not shared with any agency or organization.

RESPONSIBLE PARTY INFORMATION (If Different Than Patient)		
NAME (Last, First, Middle)	SSN#	BIRTHDATE
ADDRESS	CITY, STATE, ZIP	TELEPHONE
RELATIONSHIP TO PATIENT		

PLEASE SHOW ALL INSURANCE CARDS TO THE RECEPTIONIST

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		MEMBER / SUBSCRIBER ID # GROUP #	
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP	
NAME OF INSURED (EMPLOYEE, IF THROUGH WORK)		RELATIONSHIP OF PATIENT TO INSURED	
INSURED DATE OF BIRTH	COPAY AMOUNT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)			
NAME OF INSURANCE COMPANY		MEMBER / SUBSCRIBER ID # GROUP #	
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP	
NAME OF INSURED		RELATIONSHIP TO PATIENT	
INSURED DATE OF BIRTH	COPAY AMOUNT	EFFECTIVE DATE	EXPIRATION DATE

SCH Shenandoah Community Health | Behavioral Health

Consents

I hereby give consent for myself to receive the services of Shenandoah Valley Medical System, Inc. that does business as Shenandoah Community Health (SCH).

Patients who are unable to keep a scheduled appointment must cancel prior to 48 hours of the appointment. Appointments cancelled less than 48 hours in advance, or not all, may subject the patient to scheduling restrictions after the third occurrence.

I acknowledge that I am aware SCH's "*Notice of Privacy Practices*" for protected health information is available in the waiting area of each department or on the website at shencommhealth.com. A printed copy is available by request.

I authorize staff of SCH to take my picture or scan my photo ID and place it in my Electronic Medical Record for purposes of identification. In addition, I also give consent to SCH to take photographs of rashes, endoscopy, colonoscopy, and other medical images for the purpose of medical documentation. I understand that photographs will be protected as part of my medical record and unless otherwise required by federal or state law as noted in the SCH "*Notice of Privacy Practices*," will not be released without my authorization.

During the course of care and treatment, I understand that various types of examinations, tests, diagnostics or procedures may be necessary. This may include, but is not limited to, hearing and/or vision screening, laboratory testing, urine drug screening, injections, and other testing that the provider deems necessary. If I have any questions concerning these procedures, I will ask my clinician to provide me with additional information. I also understand my provider may ask me to sign additional Informed Consent documents related to specific procedures.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I authorized payment of insurance benefits to Shenandoah Valley Medical System, Inc. for medical services rendered to me. I understand that I am responsible for payment of fees for medical services rendered to me that are not covered by insurance or other third party payers, including copay, deductible and non-covered amounts.

If the client is a minor, a parent/legal guardian is aware and consent to this treatment.

Patient Name	Date of Birth
Signature	Date
Mother/Legal Guardian Signature (if patient is a minor)	Date
Father/Legal Guardian Signature (if patient is a minor)	Date
Witness	Date

SCH Shenandoah Community Health | Behavioral Health

PATIENT BILL OF RIGHTS

Shenandoah Community Health – Behavioral Health is committed to providing professional services of the highest quality in a way that recognizes the dignity and rights of each person we serve. As a patient, **you have the right to:**

1. Be served by qualified staff.
2. Have a treatment plan, or plan of services, developed for you as an individual, based on your needs, and participate in setting your treatment goals and working toward them.
3. Know the name and professional status of the persons providing your mental health treatment and the method of and purpose of the treatment modality proposed for you. You have the right to know what benefits you may expect from services and of any undesirable or harmful effects which may occur as a result of treatment and medication.
4. Refuse treatment recommended for you except in cases where a valid petition for emergency evaluation has been obtained.
5. Have your treatment record and all information about you kept confidential. Information will be released only with a signed release of information, except in those circumstances where a dangerous/emergency situation exists, or your treatment is mandated as a condition of probation or parole.
6. Under the law, mental health staff is required to report to the Department of Social Services if they have a reason to suspect that a child or vulnerable adult has been abused.
7. Refuse to participate in physically optional research.
8. Be informed, at your first visit, what fees you will be charged based on your ability to pay.
9. Raise questions concerning the nature of your treatment, and should your treating therapist/physician not satisfactorily answer your concerns, you have the right to bring your grievances to the Clinical Supervisor or Program Director. A copy of the Patient Grievance Procedure is available to you any time at the reception desk.
10. Obtain complete and current information concerning your diagnosis, and treatment in terms that can be understood.
11. Follow your religious beliefs. Treatment plan collaboration with the patient's clergy may be requested by the patient.
12. Be assessed and treated for pain.

I have read, acknowledge and have been advised of the above patient's rights.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

SCH Shenandoah Community Health

Authorization to Release or Obtain Confidential Information

(Autorización para divulgar u obtener información confidencial)

☐ **Primary Care** ☐ **Behavioral Health** ☐ **Women's Health** ☐ **Healthy Smiles Dental**

Patient Name (*Nombre del Paciente*):	
Date of Birth (*Fecha de Nacimiento*)	Social Security No. (*Número de Seguro Social)*

The purpose for release of information:

(*El objetivo de la divulgación de la información mencionada anteriormente es)*:

☐ Transfer of Care (*Transferencia de Cuidados)* ☐ Continuatation of Care (*Continuar el cuidado medico)* ☐ Legal *(Legal)* ☐ Other *(Otros)*_____

I hereby authorize (*Por la presente autorizo a):*

Name (*Nombre*)	
Address (*Dirección*)	
Telephone (*Teléfono*)	Fax

☐ Release or Request Confidential Information *(Divulgar u solicitar información confidencial)* ☐ Discuss Confidential Information *(divulgar información confidencial)*

Name (*Nombre*)	
Address (*Dirección*)	
Telephone (*Teléfono*)	Fax

The following medical records: *(Los siguientes expedients medicos)*

☐ Medication List (*Lista de medicamentos*) ☐ Progress Notes (*Notas de progreso)* ☐ Lab Results (*Resultados de análisis*) ☐ Psychological Evaluation *(Evaluación psicológica)* ☐ Diagnosis List *(Lista de diagnósticos)*

☐ Intake Assessment *(Evaluación Inicial)* ☐ Diagnostic Reports (*Reporte del diagnóstico)* ☐ Immunizations (*Registro de vacunas*) ☐ Appointment List *(Lista de citas)* ☐ Psychiatric Evaluation *(Evaluación Psiquiátrica)*

Other (*Otros*)_____

Dates of Service: (*de las fechas de servicio)*_____

INITIALS ARE REQUIRED FOR RELEASE OF THE FOLLOWING INFORMATION

Sus iniciales son requeridas para divulgar la siguiente información

	Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) (*Síndrome de Inmunodeficiencia Adquirido [SIDA] o infecciones con el Virus de Inmunodeficiencia Humano*)
	Behavioral/Mental Health/Psychotherapy Records (*Expediantes Conductuales/Salud Mental/Psicoterapia)*
	Treatment for Substance /Alcohol Abuse (*Tratamiento de abuso de alcohol o de sustancias)*
	Child Abuse and/or Domestic Abuse history (*Historial de maltrato infantil y/o violencia doméstica*)
	Treatment of STD (Tratamiento de Enfermedades de Transmisión Sexual)

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to Shenandoah Valley Medical System, Inc. which does business as Shenandoah Community Health. This consent will expire in one year from the date signed, unless otherwise stated as follows:
(Entiendo que este consentimiento es voluntario y que lo puedo revocar en cualquier momento [excepto a tal punto en que la acción en la cual se basa este consentimiento ya se haya efectuado] por medio de un comunicado escrito, fechado y firmado, dirigido a Shenandoah Valley Medical System, Inc., *la cual opera como* Shenandoah Community Health. *Esta autorización se vence en un año a partir de la fecha de firma, a no ser que se indique lo contrario, de acuerdo a lo siguiente:*)

- I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed and my treatment will not be affected by my refusal to sign this authorization.
  (Entiendo que puedo rehusarme a firmar esta autorización. Si lo hago, el historial médico identificado no será divulgado y mi tratamiento no será afectado por mi denegación a firmar esta autorización.)

- I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
  (Entiendo que mis registros de uso de sustancias están protegidos por la ley federal, incluidas las regulaciones federales que rigen la confidencialidad de los registros de pacientes con trastornos por uso de sustancias, 42 C.F.R. Parte 2, y la Ley de Portabilidad y Responsabilidad del Seguro Médico de 1996 ("HIPAA"), 45 C.F.R. Partes 160 y 164, y no se puede divulgar sin mi consentimiento por escrito a menos que las regulaciones dispongan lo contrario.)

- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act (HIPAA).
  (La información utilizada o divulgada conforme a esta autorización puede estar sujeta a una subsiguiente divulgación por parte del receptor y ya no estar protegida por la Ley de Portabilidad y Responsabilidad de Seguros de Salud [HIPPA, por las siglas en inglés de Health Insurance Portability and Accountability Act].

- I am entitled to a copy of this authorization.
  (Tengo derecho a recibir una copia de esta autorización.)

_____ _____

Signature of Patient parent, guardian, or legal representative
(Firma del paciente, padre, tutor legal o representante legal)

Date *(Fecha de firma)*

_____

Signature of Provider if Required.