Community Health Care Systems, Inc.

Wrightsville, GA Tennille, GA Sandersville, GA Jeffersonville, GA Irwinton, GA Dublin, GA Gray, GA McRae, GA

Patient Information and Registration Record

Patient Name		Referred by:	
Street Address:		P.O. Box	
City, State, and Zip		County	
Home Phone:	Work Phone:	Other:	
Social Security Number:		Primary Language:	
Date of Birth: / /	Sex: ☐Male ☐Female	Race: ☐African Amer/Black ☐White ☐Hispanic/ Latino ☐Other	
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated		☐Asian ☐Other Pacific Islander ☐Amer.Indian/Alaka Native	

Billing Information

Person Responsible for Bill:		Are you a Veteran? ☐Yes ☐No
Relationship to Patient:	Social Security Number:	
Responsible party's employer and address:		
Street Address	Home Phone:	
City, State, and Zip	Work Phone:	Other:

Insurance Information

Do you have insurance other than Medicare or Medicaid?	☐Yes	☐No
If yes, please give current copy of card(s) to receptionist.		
Do you have Medicare?	☐Yes	☐No
Do you have Medicaid?	☐Yes	☐No
Do you have prescription benefits with you insurance?	☐Yes	☐No

Financial Assistance Information

We offer a sliding fee scale for qualified patients. Are you interested in applying for assistance?

☐ Yes- Please give me an application

☐ No- I am not interested in applying for any financial assistance. I understand I can apply at a later date.
(A separate application and verification of income is required for this service.)

Emergency Contact Information

Person to contact in case of an Emergency:		
Relationship to Patient:		
Home Phone:	Work Phone:	Other:
If unable to contact this person, please call:		
Relationship to Patient:		
Home Phone:	Work Phone:	Other:

Advance Directive

☐ I have an Advance Directive ☐ Living Will ☐ Durable Power of Attorney for Health Care

☐ I do not have an Advance Directive and would like to obtain more information.

☐ I do not have an Advance Directive and do not want more information at this time.

Payment and Treatment Consent

Consent for Treatment: I hereby consent to any treatments, diagnostic tests or studies necessary by any physician or staff member of Community Health Care Systems, Inc. Release of information to third party: I hereby authorize Community Health Care Systems, Inc. to furnish information concerning my treatment, diagnosis, tests, and illness to third party payers for payment of fees incurred during treatment and diagnosis. I also understand that any portion that is not covered by insurance is my responsibility to pay. I understand that CHCS, Inc. may use any means deemed necessary to collect a debt. Payment is expected at time of service for all co-pays and deductibles.

Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices provided to me by Community Health Care Systems, Inc.

Rights and Responsibilities

My Rights and Responsibilities have been made available to me by Community Health Care Systems, Inc.

Signature: **Date:**