MANET COMMUNITY HEALTH CENTER - REGISTRATION FORM

email completed form to registration@manetchc.org

reg form9-042320
Revised 06/20

_____**Houghs Neck** _____**Snug Harbor** _____**Hull** _____ **North Quincy** _____ **Taunton**

Patient Information

Patient's Name: _____ (Last) _____ (First) _____ (Middle Initial) **Date of Birth:** _____ (month) _____ (day) _____ (year)

Address: _____ (Street) _____ (Apartment #) **Birthplace:** _____

_____ (City) _____ (State) _____ (Zip) **Home Phone:** _____

Cell Phone: _____

Occupation: _____ **Work Phone:** _____

Employer: _____ **Social Security #** _____

Are you Head of Household? ◯ Yes ◯ No **Please check if you are** ☐ Male ☐ Female

Number of Dependents: _____ **Marital Status** ☐ **Single** ☐ **Married** ☐ **Divorced/Separated** ☐ **Widow**

Primary Language

Race/Ethnicity ☐ **White** ☐ **Asian** ☐ **Black/Hispanic** ☐ **Native American**

Secondary Language _____ ☐ **Hispanic** ☐ **Other** ☐ **Refused**

Email Address _____

Do you have insurance? ☐ **Yes** ☐ **No** **Please check the patient's relationship to Insurance Card Holder**

☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance information

Subscriber: _____ (Name of person who gets this insurance) _____ (Subscriber's date of birth) / _____ (Subscriber's telephone #)

Insurance Plan: _____ (Name of Insurance Plan) **Doctor or Health Center Name listed on your card**

_____ (ID number) _____ (Group Number) / _____ (Group Name)

Second Insurance Plan: _____ (Name of person who gets this insurance) **Please check the patient's relationship to subscriber:**

☐ Self ☐ Spouse ☐ Child Other _____

Subscriber: _____ (Name of Insurance Plan)

_____ (ID number) _____ (Group Number) / _____ (Group Name)

Emergency and Authorization Information

If patient is a child: _____ (Parent/Guardian's Name) (Billing Address if different from above address)

PERSON YOU WANT CALLED IN AN EMERGENCY:

_____ (Name) _____ (Relationship) _____ (Work Phone)

_____ (Address) _____ (Home Phone) / _____ (Cell Phone) /

I hereby authorize the staff of Manet Community Health Center, Inc., to render such services as deemed necessary to me/my child listed above. I also authorize the release of all necessary information to insurance companies and other payers and assign to Manet Community Health Center, Inc. the authority to claim and collect insurance benefits. I will be financially responsible for any charges incurred for services not covered by my insurance plan. I acknowledge that I have received notice that I may receive a copy of Manet Community Health Center's Patients Privacy Rights and the Privacy Policies and Practices upon request.

I give my consent for the use of telehealth in my medical care and I understand that a copy of the Telehelath Policy can be provided upon request.

_____ (Patient Signature or Circle if Parent/Guardian/Other) _____ (Today's Date)

Please indicate relationship if Other _____

Manet Community Health Center

Manet Community Health Center
9 Bicknell Street
Quincy MA 02169
Secured Fax Line:
317-454-8573
317-454-8567

Authorization to Release Protected Health Information

Patient Name:		Date of Birth:	
Address:	City:	State:	Zip:
Email:	Phone: (H):	(W)	(C)

☐ I hereby authorize Manet Community Health Center, Inc. to ☐ Send my health information from: (Please list below)

Name (of facility):_____

Address:_____ City:_____ State:_____ Zip: _____

Phone:_____ Fax#:_____ Email:_____

Format of information to be released: (please check box) ☐ Paper ☐ Fax ☐ Encrypted CD

☐ I wish to pick up my records: (medical records will contact you when ready for pick-up)

Please specify information to be released or obtained. Check all that apply. Only checked items will be released.

☐ Complete Records ☐ Partial Records (last two years) ☐ Lab Results ☐ Immunizations ☐ Medication List

☐ Imaging Reports ☐ Prenatal/GYN Records ☐ Eye Records

Release of information regarding specific consent. The following categories of information in your medical record will not be released without your specific authorization, indicated by initialing each appropriate category:

☐ Behavioral/Mental Health ☐ HIV/AIDS Results/Treatment ☐ Domestic Violence ☐ Abortion ☐ Genetic Testing

☐ Sexually Transmitted Disease ☐ Alcohol/Drug Abuse ☐ Rape Sexual Assault ☐ Child/Elder/Disabled Abuse

Purpose for requested Information: ☐ Legal ☐ Insurance ☐ Specialist/Procedure ☐ Transferring out of Manet ☐ Other

By signing this authorization, I understand that:

- This authorization will remain in effect for 90 days after the above date or as specified: ——————————————————
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations
- I have the right to revoke this authorization at any time. Revocation must be made in writing to the Medical Records Department. Revocation will apply to information that has already been disclosed in response to the authorization.
- Treatment, payment, enrollment or eligibility for benefits many not be conditioned on whether I sign this authorization
- I also understand that this information may be re-disclosed by the recipient if the recipient is not required to follow the privacy regulations or statutes.

I have read and understand the terms of this authorization.

_____ _____

Patient/Parent/Legal Guardian Signature Date

*6587534w4368 A-HIPAA

Manet Community Health Center, Inc.

"Please provide email address for Patient Portal."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

Manet Community Health Center will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to your personal health information. You have the right to review this notice prior to signing this acknowledgement. The terms of this notice may change with time and we will always post the current notice at our facilities and have copies for distribution. You may ask us to restrict the use and disclosure of your personal health information. However, we are not required to agree to such a request, bit if we do agree, we are bound by law to the agreed upon restrictions.

There are times when our patients request that their health care provider include a friend or member of their family in their health care decisions. Please list any family member or friend to whom we may speak or share your personal health information (PHI).

1) Do not share my personal health information with anyone but me: ☐
2) The health center staff has my permission to leave personal health information as a message on my answering machine: ☐
_____ (Initials)
3) The health center staff has my permission to share my personal health information with the following person(s):
4)

Name	Phone	Relationship
1)		
2)		

I acknowledge that I have been given the opportunity to receive, review and ask questions regarding Manet Community Health Center's Notice of Privacy Practice.

Date: **Patient Date of Birth:**

Name:

_____ _____

Signature of patient or legal representative **Relationship to Patient**

For internal use only:
MCHC has made a good faith effort to obtain the patient's acknowledgement, but the patient's signature was not obtained for the following reason(s):

_____

_____

Staff Signature:

Manet Community Health Center

Urgent Care COVID 19 Intake Form

First Name _____ **Last Name** _____

Date of Birth _____ **Sex** _____ **Call Back Phone #** _____

Race/Ethnicity ☐ American Indian or Alaskan Native ☐ Asian/Pacific Islander

☐ Black or African American ☐ Hispanic ☐ White/Caucasian, non-Hispanic

Prior Covid 19 Test Date ___ / ____/ 2020 ◯ Detected ◯ Not detected

Covid 19 exposure risk _____

_____

Occupation_____

Last day at work _____

Date of Recent Travel out of Massachusetts _____

Living situation _____

Past Medical History _____

Medications _____

Allergies_____

Do you smoke? Yes◯ No◯

Onset of symptoms: _____days or date ___/ ____/ _____

Symptoms:

☐ Fever/chills ☐ Headache ☐ Sore throat

☐ Cough ☐ Body Aches ☐ Shortness of Breath

☐ Nausea ☐ Fatigue ☐ Loss of taste or smell

☐ Diarrhea ☐ Other _____

This is the end of the intake form. Save the form and email it to registration@manetchc.org.

****When you arrive at Manet, stay in car and please call 781-664-4597 for further instructions.**