reg form9-042320
Revised 11/20

MANET COMMUNITY HEALTH CENTER - REGISTRATION FORM

email completed form to registration@manetchc.org

Please indicate at which site you would like to be tested: ◯ North Quincy (110 W. Squantum St.) ◯ Taunton (30 Olney St.) ◯ Hull (180 G. Washington Blvd)

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 ☐ Hispanic ☐ Other ☐ Refused

Secondary Language _____

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 _____

*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: **Email:**

_____ _____

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 #** _____

Email _____

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.