MATTHEW WALKER
Comprehensive Health Center, Inc.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION (PLEASE GIVE YOUR IDENTIFICATION TO THE RECEPTIONIST)			
Patient's Last name: First: MI:			Social Security#
Have you been seen at one of our locations before? ☐ Yes ☐ No	Birth date:	Age:	Sex: ☐ M ☐ F
What is your marital status? ☐ Single ☐ Married ☐ Widower ☐ Divorced ☐ Separated			
Address:			ZIP Code:
Home Phone Number:	Cell Phone Number	Work/Alternate Phone Number	

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home phone no:	Alternate phone no:

DEMOGRAPHIC INFORMATION				
School Based? ❑ Yes ❑ No	Migrant Farm Worker? ❑ Yes ❑ No	Homeless? ❑ Yes ❑ No	Veteran? ❑ Yes ❑ No	Are You Hispanic or Latino? ❑ Yes ❑ No
What is your race? ❑ Asian ❑ African-American ❑ White ❑ American Indian ❑ Native Hawaiian ❑More than one race ❑Refuse to Report				
PREFERRED LANGUAGE: ☐English ☐Spanish ☐Arabic ☐Other:				

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)		
What insurance coverage do you have:	☐**Private Insurance** ☐ **TennCare** ☐**Medicare** ☐**Other**	
Name of Primary Insurance:		
Subscribers Name:	Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other:	
Subscribers Birthdate	Subscribers Social Security Number	
Group Name	Policy Number:	Copayment:
Name of Secondary Insurance:		
Subscribers Name:	Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other:	
Subscribers Birthdate	Subscribers Social Security Number	
Group Name	Policy Number:	Copayment:
Would you like to apply for the Sliding Fee Discount Program? ❑ Yes ❑ No		
Do you have a living will or advanced directive? ❑ Yes ❑ No If you do not have a living will or advanced directive ask our staff for information on this important subject.		

CONSENT TO TREAT

The preceding information is true to the best of my knowledge. I request MWCHC to provide me and/or the patient identified above with medical, behavioral health, dental, and/or diagnostic treatment. I understand that my primary care team is supported by many clinicians, including, but not limited to Collaborating Pharmacists and Behavioral Health professionals. I request and consent to such professionals rendering service to me. I understand that there is no guarantee or assurance as to the results of any treatment provided. I acknowledge my responsibility to pay for this care according to the fees charged by MWCHC. I understand that I will be responsible for fees that are not paid by my insurer or other third party to the extent allowed by law, contract, or applicable policies. I also agree that if I do not have any insurance, I will be responsible for fees charged by MWCHC. I agree that I have been informed of MWCHC's Notice of Privacy Practices and that a copy of such notice is available to me.

Patient/Guardian signature *Date*

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I agree to allow Matthew Walker Comprehensive Health Center, Inc. to contact me in the following methods regarding my private health information, evaluation and treatment.

PRIVACY AND COMMUNICATION PREFERENCES		
You may leave messages on my:	☐Cell phone: ☐Home phone: ☐Work phone:	
You may text me information regarding my appointments (reminders/cancellations) on my:	☐Cell phone:	
You may email information about my appointments or other general information to:	Email address:	
I would like to communicate through the Patient Portal	☐Yes ☐No	
You may send information regarding my treatment to:	☐Home address: ☐Work address:	

I authorize Matthew Walker Comprehensive Health Center, Inc. to discuss my healthcare information (which may include history, diagnosis, labs, tests results, treatment and other health information) with the contacts listed below.
I understand that by leaving the space blank I am indicating that I do not want any information released to anyone other than required or permitted by law.

Name:	Relationship:
Phone Number:	Address:
Name:	Relationship:
Phone Number:	Address:

I acknowledge that I have read and consented to the communication provided by this form. I understand the risk associated with the different methods of communication, especially email and texting, and consent to the conditions, restrictions and patient responsibilities. I understand that it is my responsibility to keep my related passwords and access to information confidential.

Patient Name Printed:_____ Date: _____

Patient Signature:_____

MATTHEW WALKER
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Name:	
Address:	
City, State Zip Code:	
Phone	Date of Birth:

It is necessary for us to ask personal questions in order to give you a discount on our services. This information will be kept on file in our Center in strict confidence. You must verify your income at least annually unless you have a significant financial change. **Your yearly income tax return, a W-2 form, payroll checks covering the last 6 weeks or copies of your Social Security checks, or other checks you may receive will be sufficient proof of income.** Your annual income and your family size will be used to calculate your discount.

☐ **I decline to apply for a discount under the Sliding Fee Discount Program**	**Signature:**

What insurance do you have that will cover _____ Initial here if you do NOT have

What is your marital status? Married Widower) Single Divorced Separated

Do you own or rent your home? Own Rent I live with someone

Amount of annual household income?	**You**	**Your Spouse**	**Your Children**	**Other People in Your home**	**Total Family Income**

Place of Employment	**You**	**Your Spouse**	**Your Children**	**Other People in Your home**

How much of your household income is from the following sources?

Sources	**You**	**Your Spouse**	**Your Children**	**Other Persons**	**Total**
Social Security					
Public Assistance					
Retirement Pension					
Rental Income					
Interest Income					
Child Support					
Other:					

How many people live in your home? _____

Name	**Date of Birth**	**Social Security Number**

I declare the above information is true and give Matthew Walker Comprehensive Health Center, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my information should change that I am required to notify the receptionist on my next visit to the clinic.

Signature Date:

Clinic Purpose Only—
Discount Code:

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SEXUAL ORIENTATION/SEXUAL IDENTIFICATION FORM

Matthew Walker Comprehensive Health Center is focused on improving the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services. Sexual orientation and gender identity can play a significant role in determining health outcomes. Gaining a better understanding of our communities served, including sexual orientation and gender identity, promotes culturally competent care delivery and contributes to reducing health disparities overall. This information will be kept confidential and used only by your health care team to meet your needs.

Name	
Date of Birth	
What is your current gender identity? (Check ALL that apply)	☐Male ☐Female ☐Transgender Male/Trans Man/FTM ☐Transgender Female/Trans Woman/MTF ☐Gender Queer
What sex were you assigned at birth? (Check ONE)	☐Male ☐Female ☐ Don't know ☐Decline
Do you think of yourself as: (Choose ONE)	☐Lesbian, gay or homosexual ☐Straight or heterosexual ☐Bisexual ☐Something else ☐Don't know ☐Choose not to disclose
How would like to be referred to? (Choose ONE)	☐He ☐She ☐They ☐Ze ☐Sie or Zie
What name do you prefer?	

Patient Signature _____ Date _____

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No Call/No Show/Late Policy

Effective, March 6, 2017 you are considered a **No Call/No Show** for not cancelling and/or not showing for an appointment.

You must cancel by a minimum of 4 hours prior to the appointment. For

- **Nashville** you can cancel by calling 615-327-9400.
- **Clarkville** you can cancel by calling 931-920-5000.
- **Smyrna** you can cancel by calling 615-984-4290.

If you are 5 minutes late for your scheduled appointment time, your appointment will be rescheduled or you have the option of being a walk-in.

After 3 No Call/No Show appointments you will not be able to schedule an appointment for 6 months. During the 6 month period you will be able to be seen as a walk-in.

_____ _____

Print Name Patient Date of Birth

_____ _____

Patient Signature Date