For Office Use Only
Location:
Med Record #:
Date:

Registration

(Please Print)

Patient's Name: *First*	*Last*	**Birthdate:**	**SSN:**

Consent to Evaluation and Treatment

Cherokee Health Systems (CHS) is dedicated to providing comprehensive primary care, dental and behavioral health services. Because wellness involves both the body and mind, our multidisciplinary team of providers work together to offer you high quality whole person healthcare. In order to provide you with comprehensive and coordinated care, your providers may involve other healthcare specialists as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure enhanced continuity of care.

Some services at Cherokee Health Systems may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These services utilize high-speed electronic connections and incorporate healthcare industry-standard encryption and data security methods. While there is no guarantee these transmissions cannot be intercepted, great care is taken to prevent all unlawful access to electronic data.

I understand, that if I am 16 years of age or older, I may consent for certain types of health services, including mental health services; if I am 18 years of age or older, I may consent for all other health services; otherwise my parent or legal guardian will need to consent to services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or child(ren) as set forth above, including any studies or procedures that CHS professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Patient's Signature (or legal guardian, if applicable) **X**____	Date __________________
Type or Print Name **X**____	Date __________________
Witness **X**____	Date __________________

Are you homeless or living in a temporary home (relative/friend's house)?	☐ Y ☐ N
Do you live in government provided public housing?	☐ Y ☐ N
Are you a Veteran?	☐ Y ☐ N
Hearing Impaired?	☐ Y ☐ N If Yes, Interpreter needed? ☐ Y ☐ N
Race?	☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Black/African American ☐ Hispanic Latino ☐ White ☐ Other Pacific Islander ☐ Decline to Report
Ethnicity?	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Report
Are you or your family member a migrant or seasonal worker who has worked on a farm or in a produce within the past 2 years?	☐ Y ☐ N Migrant ☐ Y ☐ N Seasonal ☐ Y ☐ N Aged or disabled Former agricultural worker
What is your sexual orientation? ☐ Bisexual ☐ Gay or Lesbian ☐ Straight/Not Gay or Lesbian ☐ Something Else ☐ Don't Know ☐ Decline to Report	What is your gender identity? ☐ Male ☐ Trans female/male to female ☐ Other ☐ Female ☐ Trans male/female to male ☐ Decline to Report

Statement of Privacy Practices/Client Rights and Grievance Procedures/ Well-Child/TENNder Care Programs

My initials below serve as my signature confirming I was provided materials listed.

I have received Cherokee Health System's *Statement of Privacy Practices*.	Patient Initials **X**__________
I have received Cherokee Health System's *Client Rights and Grievance Procedures* and understand my rights will be explained to me upon request.	Patient Initials **X**__________
If under the age of 21, I have received information about *Tennessee's EPSDT Program-TennCare Kids and Cherokee Health System's Well-Child Program.*	Patient Initials **X**__________

For office Use Only

I provided (Patient's Name) ____ a copy of the following:

☐ CHS's Statement of Privacy Practices
☐ CHS's Client Rights and Grievance Procedures
☐ Tennessee's EPSDT Program-TennCare Kids and CHS's Well-Child Program (if under the age of 21)

Patient's Name: *First* *Last*	Birthdate

Contact Information

Patient Address	City/State/Zip Code	Phone #
		( )
Emergency Contact Name/Relationship Contact Address	City/State/Zip Code	Contact Phone #
		( )

Information to Release to Contact

☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

Contact Name/Relationship Contact Address	City/State/Zip Code	Contact Phone #
		( )

Information to Release to Contact Please check all that apply below

☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

Contact Name/Relationship Contact Address	City/State/Zip Code	Contact Phone #
		( )

Information to Release to Contact Please check all that apply below

☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

I authorize Cherokee Health Systems to leave messages on the answering machine(s) at my contact number(s).

☐ Y ☐ N

I give my permission for my provider(s) with Cherokee Health Systems to communicate [orally or written (i.e. summary letter)] with the following individual(s) in regard to:

☐ Examination ☐ Diagnosis ☐ My Treatment ☐ Specific Purpose:____________________________	Contact Name: Phone:	Relationship to Patient:
	Contact Name: Phone:	Relationship to Patient:

By signing below, I authorize Cherokee Health Systems to release information concerning me, my minor child, or legal charge as indicated above. I understand that I may revoke this consent to release confidential information at any time with written consent, but that it will not affect any communication prior to notification of cancellation **This authorization does not serve as consent to release documents.**
Unless I revoke this authorization, this authorization shall remain in effect for one (1) year.

Patient's Signature (or legal guardian, if applicable) **X** ____ Date ___________________________

Do you have a plan in case you are unable to make your own healthcare decisions?	Social Security Number
☐ Y ☐ N	- -

Consent to Receive Text and/or Email Messages

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, and/or to provide general health reminder/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Cherokee Health Systems.
By initialing below, I consent to receive text messages from Cherokee Health Systems at my cell phone and any number forwarded or transferred to that number to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/health information unless I request a change in writing (see revocation below).

Patient Initials **X**________________

The **cell phone** number I authorize to receive text messages and the **email address** I authorize to receive email messages for appointment reminders and/or general health reminders/information are:

Cell Phone Number:		**Revocation Use Only** I hereby revoke my request to receive any future appointment reminders and general health information via **text messaging**. Patient/Patient Representative Signature:
Email Address:		**Revocation Use Only** I hereby revoke my request to receive any future appointment reminders and general health information via **email**. Patient/Patient Representative Signature:

Patient's Name: *First* *Last*	**Date of Birth**

Financial Information
As a patient of Cherokee Health Systems, you are responsible for the payment of all fees associated with your care. However, we believe that money, or a lack of money, should never keep you from getting the care you need so all CHS services are available on an "ability to pay" basis. This means your income and family size will determine the amount you are asked to pay. By signing below, you agree to provide us with accurate information, now and in the future, and that you will attempt to pay your fees on the day you get your services. You may also choose to decline providing your financial information to us. However, by declining, you will not be eligible for income-based discounts, and will be responsible for payment of the full fees associated with your care.
***Proof of Income is required for all discounts**.: Before a discount can be arranged, our funders require that you provide written proof of your total household income. You may use paycheck stubs for at least three consecutive pay periods, benefits check stubs, W-2 forms, a copy of your most recent federal income tax forms, or a copy of applications for any other agency benefits if they include household income (i.e., applications made at DHS, Helping Hands applications or cards, etc.*)

Patient's Signature (or legal guardian, if applicable) **X** ______________________________	☐ I choose to decline sharing financial information

Household Income (include all income from persons included in the count below):			
Number of people living in your household:			
Sources of Income	**You**	**Others in your home**	**Total**
Wages from Employment			
Self-Employment			
Other Sources of Income	**You**	**Others in your home**	**Total**
Social Security			
Public Assistance			
Pensions			
Rental Income			
Child Support/Alimony			
Other (specify)			
		Grand Total:	

Authorization for Insurance Billing/Release of Information

Health insurance policies may cover a portion of the fees and CHS staff will assist you in making claims. It is expected that you will inform us of changes in your family status or health insurance coverage. Please fill in the name of your insurance company(s), and sign below.

By signing below, I authorize Cherokee Health Systems to assist me in obtaining third party benefits, to file benefit claims on my behalf, and to release any information necessary for the processing of my claim(s) to any of the insurance companies or third-party benefit agents listed below. I understand that such information may include diagnosis, dates of service, types of treatment, results of evaluations/assessments, actual progress notes, and other information about services received. This release shall remain in effect until all claims filed on my behalf have been processed.

I authorize and request direct payment of my health insurance benefits to Cherokee Health Systems. This authorization shall apply to all covered health services that I receive at the Center. If requested, I have been provided with a copy of the fee scale.

Guarantor Name		**Relation to Patient**		
Guarantor Contact Number		**Guarantor SSN & DOB**	**SSN:**	**Birthdate:**
Primary Insurance Name:		**Primary** Insurance ID#		
Secondary Insurance Name:		**Secondary** Insurance ID#		
Tertiary Insurance Name		**Tertiary** Insurance ID#		

Patient's Signature (or legal guardian, if applicable) **X** ______________________________ Date ________________

Witness ______________________________ Date ________________

Cherokee HEALTH SYSTEMS

EARLY CHILDHOOD DEVELOPMENTAL QUESTIONNAIRE

Child's Name____________________________ Sex_______ Date of Birth____________________ Age_________

Completed by______________________________ Relationship to Child_____________________________

Health

Birth History

Complications of pregnancy____

Complications of delivery____

NICU stay____

Weeks of gestation________ Birth weight_______ Alcohol/Drug /Cigarette use during pregnancy______________________________

Medical Issues

☐ Vision Problems	☐ High fevers	☐ Ear Infections
☐ Hearing Problems	☐ Head Injuries	☐ PE (ear) tubes
☐ Seizures	☐ Broken Bones	☐ Tonsils/Adenoids removed
☐ GI issues, reflux	☐ Stitches	☐ Other surgeries
☐ Allergies, asthma, reactive airway disease	☐ Hospitalizations	☐ Other medical issues

Please explain items checked above: ____

____

Current Medications

Medication	When Started	Purpose

Eating

Are there eating difficulties? ____

Does your child eat at least 20 different foods including at least 2 fruits and 2 vegetables? _____________________________________

Has your child had intervention (like feeding therapy) for problems eating? ____

How much caffeine (sweet tea, soft drinks, coffee, etc.) does your child drink per day?____

Sleeping

Does your child have trouble falling asleep? _______________ Does your child have trouble staying asleep? ______________________

How many hours of sleep per night (give a range if variable)? ____

Sensory Processing

Does your child currently have sensory issues (overly sensitive, or overly absorbed)?

Sense	Yes/No	Describe
Vision (stares at things a long time)		
Auditory (covers ears, bothered by noise)		
Tactile (distraught when messy)		
Taste (avoids food textures)		
Smell (gags w/odor, sniffs things)		
Pain tolerance, high or low		

Does your child engage in any stereotyped or repetitive motor mannerisms?

□ Arm Flapping □ Finger Flicking □ Lining up Objects □ Spinning □ Rocking

Describe____

Any other sensory concerns? ____

____

____

Developmental History

Motor

Do you think your child was delayed in reaching early motor milestones, like sitting, crawling, walking? __________________

At what age did your child walk? __________

Do you think gross motor (arm and leg) skills are up to age level? ____

Do you think fine motor (finger) skills are up to age level? ____

Language Development

Is there another language spoken in the home besides English? Yes_____ No_____ What? _____________________________________

Age at first word _____________________ Example____

Is your child's vocabulary up to age level? Estimated vocabulary size? ____

How does your child request?

□ Gesture □ Point □ Lead to □ Bring □ Sign □ Tantrum

□ Words? Give examples::____

□ Sentence? Give examples:____

Was there ever a time when their language skills regressed or were lost? Describe: ____

Can your child follow one step directions (Let's go eat? Let's go bye bye?)____

Can your child follow a direction to "go get" something? ____

Does your child respond when you call his/her name? ____

Does your child understand the word "no"? ____

Can your child point to body parts named? ____

Can your child answer "What's your name?"____

Can your child answer yes/no questions reliably? ____

Can your child answer when a peer asks "What's your name?"______________________________________

	Yes	No	If yes, describe:
Does your child echo/repeat meaningless phrases heard?			
Does your child say the same word or phrase over and over?			
Does your child mix up pronouns? (I, you, me, he, she)			
Does your child quote phrases from movies or TV shows?			

Self-Care

Is your child toilet trained? __________ Does your child cooperate with toilet training?___________________________

Does your child cooperate with other self-care tasks such as dressing, bathing, and brushing teeth?___________________

Intervention

Does/did your child receive TEIS services? ____________

Does/did your child attend preschool or daycare? ______ If yes, where?____________ Teacher Name: ______________

Language therapy? ___________________________

Occupational therapy? _________________________

Physical therapy?____________________________

Family Information

Child currently lives with____

Is your child affectionate? ____

Does your child seem to be able to read your feelings and show empathy? ________________________________

Do you think your child makes good eye-contact? ___________Does your child smile at you? ___________________

Does your child play peek-a-boo or patty cake? ______________

Does your child show you things that interest him or her? ____________________________________

Does he/she want you to join him/her when he/she is enjoying something? ________________________________

Does your child ask for help? __________How? ____

Does your child imitate things you do? _______Give examples: ______________________________________

Social Functioning with Peers

Does your child show an interest in others the same age? ____

Does your child watch other children at play? ____

Does your child approach other children? ____

With peers, can your child join:

Chase games? ____________________

Ball play? ______________________

Imitation (copy cat) play? ____________Examples:____

Behavioral Issues

Does your child seem anxious? ______ Unusual fears? ____

More than average afraid of:

- ☐ The dark
- ☐ Storms
- ☐ Strangers
- ☐ Bugs, bees
- ☐ New places
- ☐ Changes in routine

Describe any stressful or scary experiences such as a car accident, natural disaster, abuse, or witnessing violence___________________

____

What does your child do when angry?

- ☐ Yell, cry, scream
- ☐ Drop to the floor, go limp
- ☐ Throw things
- ☐ Hit, kick, bite others
- ☐ Self-injury

Other descriptions of temper? ____

On average, how long do outbursts last (up to 5 minutes, 30 minutes, etc.)? _______ How long are the worst outbursts?____________

How often do the outbursts occur (daily, weekly, monthly)?_______________________

What triggers outbursts?____

What do you do when your child is having outbursts?____

Play/Interests

Does your child show an interest in?

- ☐ Balls
- ☐ Toy cars
- ☐ Blocks, legos
- ☐ Figurines
- ☐ Books
- ☐ Tech toys

How much screen time does your child have per day (TV, tablets, videogames, phones, etc.)__________________________________

Does your child pretend to:

Talk on a phone? ______________________________________

Be an animal, like a cat or dinosaur? ______________________

Cook or play doctor? __________________________________

Does your child have any unusual interests? ____

What are your child's favorite toys or activities? ____

Does your child seem absorbed or "obsessed" by any objects or activities? ____

____

What are your child's strengths:

____

____

____

Is there anything else that you would like for us to know about your child that we did not ask? __________________________

____

____