PATIENT INFORMATION

Dear Patient: We are a non-profit clinic that provides low cost health care on a sliding scale. Visit costs for patients are determined by a sliding fee scale that is calculated based on income and household size. Due to new federal reporting regulations, the following information is now required for each patient. Please note that all information is confidential. We appreciate your cooperation with these new reporting requirements and will need to collect this information on an annual basis.

(Please give your insurance card to the receptionist.)

Today's date: / /

Name: Last First Middle

Social Security #: - - Date of Birth: Age:

Check one: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Nickname: Previous Names:

Home Address:

City: State: Zip:

Mailing Address: (Street or P.O. Box)

City: State: Zip:

Home Phone: Cell Phone: Work Phone:

E-Mail Address:

Occupation: Employer:

Employer Address:

City: State: Zip:

Gender Identity: (check one)

- ☐ Male
- ☐ Female
- ☐ Transgender Male (Female to Male)
- ☐ Transgender Female (Male to Female)
- ☐ Genderqueer, neither exclusively male or female
- ☐ Prefer not to disclose
- ☐ Other

Sexual Orientation: (check one)

- ☐ Straight (Not Lesbian or Gay)
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Don't Know
- ☐ Prefer not to disclose
- ☐ Other

Insurance Information

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? (Circle one) Yes / No

If YES, please check one: ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Other:

Name of Primary Insurance: Policyholder's Name:

Insurance Information Continued

Policy #: Co-Payment $:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policyholder's Date of Birth:

Name of Secondary Inurance: Policyholder's Name:

Policy #: Co-Payment $: Policyholder's Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Parent/Guardian Information

(To be completed if the patient is a minor.)

Mother/Guardian's Name: Mother's Maiden Name:

Mother/Guardian's Date of Birth: Mother/Guardian's Social Security #: - -

Mother/Gaurdian's Phone #:

Father's Name: Father's Date of Birth:

Father's Social Security #: - - Father's Phone number:

Patient's Next of Kin:

Address: (if different from above)

City: State: Zip:

Person Responsible for Payment: Relationship to Patient: Occupation:

Employer: Employer Phone #:

Employer Address:

City: State: Zip:

INSURANCE INFORMATION:

I hereby assign all payments of benefits for Medical/Dental Services rendered to myself or dependants under the above plan to Innis Community Health. I understand that I am financially responsible for any charges not covered by the assignment. I also hereby authorize release of information required in the course of these services as may be needed to process my claim. Claims cannot be filed without your signature.

CONSENT FOR TREATMENT:

I hereby authorize or consent to the diagnostic and/or therapeutic treatment for myself or the minor named below that may be considered necessary or advisable by the professional healthcare providers of the clinic.

Parent/Guardian Signature: Patient's Name: (Print) Date:

Additional Patient

Starting with most recent employer, provide the following:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widow

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student ☐ None

Race: (check one)
- ☐ Asian
- ☐ Native–American
- ☐ Pacific Islander
- ☐ Caucasian
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ More than one race
- ☐ Prefer not to disclose

Housing Status: (check one)
- ☐ Rent/Own
- ☐ Street
- ☐ Homeless
- ☐ Doubling Up
- ☐ Transitional
- ☐ N/A

Agricultural Status: (check one)
- ☐ Mirgrant Worker
- ☐ Seasonal Worker
- ☐ Dependant of Migrant
- ☐ Dependant of Seasonal
- ☐ N/A

Ethnicity: (check one) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Are you a Veteran? (circle one) Yes / No

Preferred Language:

Primary Care Physician:

Preferred Pharmacy:

Advanced Directive/Living Will? (circle one) yes / no

**If YES, did you bring a copy with you today? Yes / No

Do you have access to transportation for health appointments? (circle one) Yes / No

Annual Household Income: (check one)
- ☐ Prefer not to disclose
- ☐ Less than $10,000
- ☐ $10,001—$20,000
- ☐ $20,001—$40,000
- ☐ $40,001—$60,000
- ☐ $60,001—$100,000
- ☐ $100,000+

Are you displaced due to a natural disaster? (circle one) Yes / No

Do you currently qualify for any government programs such as Medicaid, WIC, welfare, food stamps, Social Security disability, or unemployment? (circle one) Yes / No

**If YES to above question, please list:

☐ Prefer not to disclose

If you do not currently have Medicaid, have you ever applied for Medicaid? What was the outcome? (circle one) Yes / No ☐ Prefer not to disclose

Religious Affiliation:

Highest Level of Education Completed:

Number of people living in your household:

Do you have prescription drug coverage? (circle one) Yes / No

In Case of Emergency

Name of Local Friend or Relative:

Relationship to Patient:

Home Phone: Work Phone: Cell Phone:

Preferred Method of Contact: (Check Two) ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Postal Mail ☐ Email ☐ Fax

Privacy – HIPAA Authroization Form

Disclaimer: This document is provided solely for reference purposes. Covered entities under HIPAA are advised to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.

I, give permission to Arbor Family Health to:

☐ Use the following protected health information, and/or (Name(s) of entity to recieve information)

☐ Disclose the following protected health information to: (Relationship to Name listed)

Information to be given (check all that apply):

☐ Medical Records
☐ Treatment Records
☐ Diagnostic Records
☐ Other

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations (HIPAA).

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or eligibility of benefits.

You may inspect or copy protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in person at the office location or in writing at any time by sending written notification to Arbor Family Health at 6450 Hwy 1, Batchelor, LA 70715. Your notice will not apply to actions taken by or any actions prior to this office receiving a written and signed request revoking the authorization.

NOTICE OF PRIVACY PRACTICES: I have been provided with and understand the contents of the Notice of Privacy Practices for Arbor Family Health and its entities. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations at Arbor Family Health and its entities are not required to agree to the restrictions.

Signature of Participant or Personal Representative: Date: