Health First
Community Health Center

PATIENT INTAKE

Please provide us with your insurance and valid ID

PATIENT'S EMPLOYER

NAME OF EMPLOYER	
TYPE OF BUSINESS	OCCUPATION
EMPLOYMENT STATUS € FULL-TIME € PART-TIME € RETIRED € DISABLED	

PRIMARY INSURANCE

TYPE OF PRIMARY COVERAGE € MEDICAID € MEDICARE € PRIVATE INSURANCE € NONE € OTHER _____

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

PREFERRED PHARMACY

PHARMACY NAME	PHARMACY LOCATION

CONSENT FOR TREATMENT

I, the undersigned, certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process the claim for treatment, payment, or operations. I authorize payment of medical benefits to Health First Community Health Center (HFCHC), provider or suppliers for services. I hereby authorize the provider and whomever else he/she may designate as his/her assistant(s), to administer those treatments and procedures, which in his/her opinion are deemed necessary. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is expected at the time of service. HFCHC will bill my insurance as a courtesy. I authorize HFCHC to contact me by phone. If signing as a parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions. If I have sole decision-making capability to obtain treatment for my child. Upon request, I will provide appropriate court documentation to HFCHC prior to treatment.

Patient or parent/guardian Signature_____ **Date**_____

Responsible Party's Signature_____ **Date** _____

Witness _____

RELEASE OF MEDICAL RECORDS

In the event that the provider refers me to a specialist (a provider outside of Health First Community Health Center (HFCHC)), I hereby authorize HFCHC to release my medical records as required to the indicated specialty provider for the purpose of continuity of care.

I understand this release does not apply to my behavioral health records, HIV/AIDS status, nor substance (drug, alcohol) use disorder information, if it exists. If there is a need for the release of behavioral health records, etc, I will be notified of the need to sign a separate release of information form.

I understand that if I am referred to a specialist, HFCHC will make the referral to the qualified entity of the patient's choice. If the patient's preferred entity refuses the referral, cannot see the patient in a timely manner, or is unavailable, the HFCHC referral team will seek similar specialists to provide care for the patient.

I understand that this release will stay in force unless I revoke it in writing to HFCHC.

Patient or parent/guardian Signature_____ **Date**_____

Co-Signature (if needed) _____ **Date**_____

ACKNOWLEDGEMENTS (PLEASE READ, CHECK THE BOXES, AND SIGN/DATE BELOW)

1. **Cancellation of Appointments. I agree to schedule appointments for my treatment. I agree that I will call and cancel my appointment at least 24 hours prior to the appointment time, if cancellation is necessary.**
2. **No Call / No Show. I understand that missing 3 appointments in a role may cause me to be subject to walk in visits only**
3. **Transportation. I understand that if I have any problems getting myself or my child to an appointment, I can let Health First know and they may be able to help me with transportation.**
4. **Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices.**
5. **Patient Rights and Responsibilities. I have received a copy of my Patient Rights and Responsibilities.**
6. **Responsibility for Payment. For and in consideration of services rendered, or to be rendered, to the named patient, I do hereby promise to pay HFCHC the full amount of all charges incurred. I/we understand that HFCHC will file commercial insurance as a courtesy and will allow 30 days for the insurance to resolve the outstanding charges. After the 30 days, any remaining charges will become due and payable by the financially responsible person(s).**
7. **Co-pays, co-insurance and sliding scale fees are due at the time of service.**

Patient or Parent / Guardian Signature:_____**Date:**_____

Co-Signature (if needed)_____**Date:**_____

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** – Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Medication history transactions** – Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at HFCHC, as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) use disorder, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form, you are agreeing that your provider at HFCHC may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not influence any actions taken prior to receiving the revocation.

Understanding all the above, I hereby provide informed consent for Health First to enroll me in this ePrescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

_____ Print Patient Name _____ Patient DOB

_____ Signature of Patient or Guardian _____ Today's Date

_____ Relationship to Patient

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Community Health Center

PATIENT INTAKE

Please provide us with your insurance and valid ID

PATIENT'S INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER	BIRTHDATE	SEX AT BIRTH ☐ MALE ☐ FEMALE	NICKNAME

PATIENT'S BILLING/MAILING ADDRESS

STREET OR PO BOX		
CITY	**STATE**	**ZIP**

PATIENT'S PHYSICAL ADDRESS (if different from billing/mailing address)

STREET ADDRESS		
CITY	**STATE**	**ZIP**

PATIENT'S CONTACT INFORMATION

HOME PHONE #	CELL PHONE #	E-MAIL ADDRESS

Preferred Method for Notifications (check all that apply) ☐ Phone ☐ Text ☐ E-mail ☐ Automated Recordings

PATIENT'S EMERGENCY CONTACT INFORMATION

NAME	ADDRESS	RELATIONSHIP	CONTACT PHONE NUMBER

PATIENT'S ADDITIONAL INFORMATION – For Purposes of Grant Funding

RACE

- AMERICAN INDIAN/ALASKAN NATIVE
- ASIAN
- BLACK/AFRICAN AMERICAN
- NATIVE HAWAIIAN
- OTHER PACIFIC ISLANDER
- WHITE
- MORE THAN ONE RACE

ARE YOU OF:

☐ HISPANIC ☐ LATINO
MEXICAN ☐ CHICANO
☐ PUERTO RICAN CUBAN
☐ OTHER

AGRICULTURAL WORKER (if applicable)

☐ MIGRANT ☐ SEASONAL

PRIMARY LANGUAGE

☐ ENGLISH ☐ SPANISH
☐ OTHER _____

ARE YOU A VETERAN OF THE U.S. ARMED FORCES?

☐ YES
☐ NO

DO YOU NEED INTERPRETER SERVICES?

☐ YES ☐ NO

MARITAL STATUS

☐ SINGLE
☐ MARRIED
☐ DIVORCED
☐ WIDOW
☐ LEGALLY SEPARATED
☐ LIFE PARTNER
☐ OTHER _____

HOUSEHOLD SIZE

☐ 1 ☐ 6
☐ 2 ☐ 7
☐ 3 ☐ 8
☐ 4 ☐ 9
☐ 5 ☐ 10

☐OTHER _____

ESTIMATED HOUSEHOLD INCOME

$ _____

☐ WEEKLY
☐ BI-WEEKLY
☐ MONTHLY
☐ ANNUALLY

GENDER IDENTITY

☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE (Female-to-Male/FTM)
☐ TRANSGENDER FEMALE (Male-to-Female/MTF)
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION

☐ STRAIGHT or HETEROSEXUAL
☐ LESBIAN, GAY or HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ HOOSE NOT TO DISCLOSE

HOUSING STATUS

☐ CURRENT RESIDENT OF PUBLIC HOUSING
☐ HOMELESS ___Doubling Up ___Shelter ___Transitional ___Unknown/Other _____
☐ NOT HOMELESS AND NOT CURRENT RESIDENT OF PUBLIC HOUSING

RESPONSIBLE PARTY'S INFORMATION (if different than patient)

NAME (Last, First, Middle)			PREVIOUS LAST NAME	NICKNAME

SSN	BIRTHDATE	SEX	RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY'S BILLING/MAILING ADDRESS (if different than patient)

STREET OR PO BOX			
CITY	**STATE**	**ZIP**	**HOME PHONE NUMBER**

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Sliding Scale Program

A **sliding scale** discount program is available for our patients who may have difficulty paying, regardless of insurance status.

☐ **Yes**, I am interested in information regarding the sliding scale program.

☐ **No**, I am not interested at this time in the sliding scale program.

Signature: _____

Date:_____

Once the paper is signed, please return it to the receptionist.

Health First
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Authorization for Release of Patient Information/Minor Consent to Treat
Health First Internal Clinic Use Only

GENERAL PATIENT INFORMATION:(please print)

Name of patient: _____ Date of Birth: _____
Relation to minor: _____ Phone Number: _____
Address: _____

I _____ **(please print)** do hereby Authorize the following individuals to bring my minor child/children to appointments at Regional Health Care Affiliates, Inc. dba Health First Community Health Center in my absence. I hereby grant permission for them to have future decision-making ability in my absence.

NAME	**TELEPHONE**	**RELATIONSHIP TO PATIENT**

I hereby authorize Regional Health Care Affiliates, Inc. dba Health First Community Health Center, to release to the person(s) listed below any information regarding my care, diagnoses, appointment times, test results, procedures, behavioral health information, HIV/AIDS status, or prognosis at any time.

NAME	**TELEPHONE**	**RELATIONSHIP TO PATIENT**

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witness Date

Note: This information and directions will remain in force until the patient or responsible party revokes the document.