New Patient Application

<u>What to Bring for Reduced Fee</u>

1. Proof of **TOTAL** household income for **ALL** those living in the home.
   Must provide:
   - A month's worth of paycheck stubs
     (If you are paid cash or if you have not yet received your 1st check, bring a written statement from your employer(s) stating pay rate & weekly hours worked)

     AND
   - Last year's federal tax return (1040 or other)
     (If you did not file taxes, complete the 4506-T Tax form enclosed in this packet)

2. Proof of Residency. (All Items must contain applicant's name correct address and current date **Within 30 days**)
   Acceptable Documents for Proof of Residency:
   - Current piece of mail such as, utility bill, insurance bill, bank statement, etc.
   - Rent payment receipt

-A DRIVERS LICENSE OR PAYCHECK STUBS WILL NOT BE ACCEPTED AS PROOF OF RESIDENCY-

****If you have insurance, you are not required to bring the proofs. However, this information is very important to the grants we receive that keep our doors open to services.* ***If your insurance were to lapse and we do not have complete information on file, you will not be eligible to utilize the sliding scale discount.***

All office visits require a nominal fee of at least $15, when you turn in your packet ask the receptionist about the fee you will be required to pay at the time of visit

- Other fees may be incurred depending on the purpose of the visit
- We accept Cash, Check, Credit/Debit Card (Not American Express)

Late Policy:

Patients will be given up to a five minute grace period to arrive after their scheduled appointment time. If you arrive after the five minute grace period you will have to reschedule your appointment and it will be considered a No-Show. When you have four no-shows (including cancellations less than 24 hours prior to your appointment time) for any of the Family Health Centers for all departments combined you will be discharged from the practice.

Patient Information

DATE________________

PATIENT'S NAME____ AGE_______
DATE OF BIRTH______________________SOCIAL SECURITY #____________________________
Please list your current *home* address or indicate if homeless or *living with a friend temporarily:*
ADDRESS____APT. #___________________
CITY_________________________________STATE_____________ZIP CODE______________
Do you have a mailing address:____
HOME PHONE#___________________________WORK #_________________________________
CELL PHONE#______________________________ **Are you a veteran?** Y or N
Can we leave a message about test results on a recorder? Y or N Which # _______________
Can we text message you? Y or N Which # _______________ Email:_______________
Do you have a living will? Y or N, (please bring a copy for your chart) Occupation: __________
Do you live in public Housing? Y or N
Do you live in a homeless shelter? Y or N
Do you have a legal guardian, if yes please list name here____________________________

Circle one of each:

Race - Black/African American, White, Multi-racial, Native Hawaiian, Other Pacific Islander, Asian, American Indian/Alaska Native
Ethnicity: Hispanic, Non-Hispanic
Language: English, Spanish, Arabic, Mongolian, Chinese, Japanese, Other____________
Marital Status –Single, Married, Divorced, Widowed, Legally Separated
Education Level- Less than H.S., GED, H.S. Diploma, Some College, College Degree
Sexual Orientation: Straight, Gay, bisexual, other, unknown, not disclosed
Gender Identity: Male, Female, Trans male, Trans Female, Genderqueer, other, not disclosed

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TO BE COMPLETED BY PARENT OR GUARDIAN IF THE PATIENT IS UNDER 18 YEARS OLD

Do you have insurance? Y or N

Primary Insurance: ____
Subscriber (if other than patient) ____
Subscriber DOB: _______________Relationship to Patient___________________________
Secondary Insurance: ____
Subscriber (if other than patient) ____
Subscriber DOB: _______________Relationship to Patient___________________________

EMERGENCY CONTACT (Person who does not live with you)

Name_______________________________Ph#______________Relationship__________________
Address____ Apt #____________________
City___________________________________ State_____________ ZIP CODE_______________

PRIVACY NOTICE

We affirm our commitment to comply with Federal and State requirements pertaining to the use & disclosure of your protected health information. A copy of our policy has been given to you.

___________________________________ ________________________
Signature Date

Updated FHCSI August 2015

FINANCIAL INTAKE FORM

Date: ________________

Including yourself, how many people live in the home? __________
(Do not include anyone who pays you a fee to live in the home such as a roommate)

Complete the following for each member of your household. ***(INCLUDE YOURSELF AND ANY CHILDREN)***

Name______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$ __________________ TANF
$ __________________ Veterans Benefits
$ __________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only
Sub Total $___________

Name______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$ __________________ TANF
$ __________________ Veterans Benefits
$ __________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only
Sub Total $___________

Name ______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$ __________________ TANF
$ __________________ Veterans Benefits
$ __________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only
Sub Total $___________

Name______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$ __________________ TANF
$ __________________ Veterans Benefits
$ __________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only
Sub Total $___________

Name______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$ __________________ TANF
$ __________________ Veterans Benefits
$ __________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only
Sub Total $___________
Total $ ___________
Verified by: ___________

All of the stated information is true and accurate. I understand that if I do not accurately report the total household income, my county of residence and my insurance status I will be responsible for any hospital services, physician services and medication costs at full market rate.

Signature: ______________________________ Date: ____________________

Adult Medical History

Date________________

Please list providers name if you have a preference____

Why are you needing to be seen? ____

____

Do you need to be seen for mental health issues? If yes, please explain: Y or N

____

____

PHYSICIANS CURRENTLY PROVIDING TREATMENT

Name	Reason for Treatment

MEDICATIONS

Name	Amount	Frequency	Physician

HOSPITALIZATIONS/SERIOUS ILLNESSES

Name	Date	Reason

Have you been in the hospital or Emergency Room recently, if yes please indicate when and where. Y or N

When: ____________________ Where: ____________________

ALLERGIES TO FOOD/MEDICINES____

SURGERIES

Surgery	Date/ Hospital

PATIENT/FAMILY MEDICAL HISTORY

	Patient Yes	Patient No	Family Yes	Family No		Patient Yes	Patient No	Family Yes	Family No
Allergy	___	___	___	___	Speech Problems	___	___	___	___
Epilepsy	___	___	___	___	Eating Problems	___	___	___	___
Tuberculosis	___	___	___	___	Visual Problems	___	___	___	___
Heart Trouble	___	___	___	___	Special Diet	___	___	___	___
Diabetes	___	___	___	___	Respiratory Problems	___	___	___	___
High Blood Pressure	___	___	___	___	Psychological Problems	___	___	___	___
Cancer	___	___	___	___	Bowel Problems	___	___	___	___
Arthritis	___	___	___	___	Hearing Problems	___	___	___	___
Bladder Problems	___	___	___	___	Alcohol Use	___	___	___	___
Smoker	___	___	___	___	Breast Diseases	___	___	___	___

Comments____

____

FAMILY HEALTH CENTERS OF SOUTHERN INDIANA

Acknowledgement of Financial Obligation

In the event that you are in need of labs and/or tests you will be referred to an area hospital (Clark, Floyd or Harrison), based on the county you live in. Each hospital determines the fees (if any) they will charge you. Any payment arrangement must be made between you and the hospital. It is recommended that you speak with each hospital **before** you obtain your labs, services and/or test. If you fail to call the number listed on your bill from the hospital, within the designated time period, you may be turned over to the Hospital's Collections Department. At that point you will ***no longer be eligible for a discount.***

Contact numbers for all hospitals:

Clark- (812) 283-2337

Floyd- (812)-949-5860

Harrison-(812)-738-7846 (requires a financial assistance application to be filled out as well)

The Family Health center DOES NOT pay any medical bills for our patients

I agree to be referred to an area hospital for labs, services and/or tests:

YES _____ **NO_____**

I verify that I have read this document and that I fully understand the terms of the agreement

Signature: ______________________________ Date:_________________________

Printed Name: ____________________________

Acknowledgement of Referral

If any point you are referred to a specialist for medical care, the specialist's office determines what fees (if any) they will charge you. Any Payment arrangement must be made between you and the specialist's office. It is recommended that you speak with the specialist's office billing department before your appointment to understand any fees that you may be charged.

Care or services received from any providers that are not staff at the Family Health Centers of Southern Indiana is beyond our control. When you see a specialist, you are entering into an agreement with that office.

The Family Health Centers of Southern Indiana do NOT pay any medical bills for our patients

Failure to keep an appointment or to cancel an appointment with the specialist may result in charges to you from that physician. Failure to call and cancel or reschedule within twenty-four hours of your appointment may jeopardize your ability to seek future care from the specialist.

I understand the terms of this agreement

Signature:___________________________ **Date:**___________________

Printed Name:________________________

I understand the terms of this agreement, but choose not to be referred

Signature:___________________________ **Date:**___________________

Printed Name:___________________________

FAMILY HEALTH CENTERS OF SOUTHERN INDIANA

CONSENT FOR TREATMENT

I hereby give permission for myself/my child, ______________________________,
To receive medical treatment by the Family Health Centers of Southern Indiana, Inc. I understand that my responsibility in accepting treatment by the Family Health Center and/or referral physicians include compliance with follow-up visits, prescribed tests and the correct use of prescribed medications.

No one will be turned away for service. Patients may request sliding fee scale if they are within 200% of federal Poverty Guidelines and residents of Clark County. **Fees are due at the time of service.** Arrangements may be made for delayed payment if requested.

______________________________ ____________________
Patient Signature Date

____
Relationship to patient if signed by parent/guardian of minor child

Patient Consent Form

By signing this form, you are granting consent to the Family Health Center to use & disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this information for the treatment, payment and health care operations. Before you sign this consent we encourage you to read it in full.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

______________________________ ____________________
Signature Date

____
Witness

CONSENT FOR TREATMENT IS EFFECTIVE FOR ONE YEAR AFTER THE ABOVE DATE

Consent for Release of Information

Please, complete all required fields. **Today's Date:** ______________________

Name: ____________________________ **DOB:**

____

I, Authorize the Family Health Centers of Southern Indiana to release my healthcare information or records over the phone, by mail, or via fax to my parents, legal guardian/ custodian, relatives or designated person, AS IT APPEARS BELOW ONLY:

Name of person or Organization	Relationship	Phone#

I declare that I agree to the information on this form, and my signature proves it.

Signature: ______________________________________

Date Signed: ____________________________________

Narcotic Agreement

1. Only the provider who is following your care or a partner in his/her practice may prescribe narcotics or other controlled substances for you.
2. Your provider will abide by all State and Federal laws regarding the prescription of narcotics and other controlled substances.
3. If you do not comply with the terms of this agreement, your provider will not prescribe narcotics or controlled substances for you and your provider may terminate your care. You will be notified in writing of any termination and given thirty (30) days to find another provider. During these thirty days, your provider will continue to furnish care for you only in emergencies.

Preferred Pharmacy MUST be chosen

____________________________ ____________________________

Designated Pharmacy Name Pharmacy Location

By signing below, I indicate that I agree to the conditions noted above**. I understand that violation of this agreement may result in my provider no longer providing prescriptions for narcotics or other controlled substances.** It could also potentially lead to prosecution through the legal system.

________________________ ____________________

Patient Signature Date

Family Health Center
Clark, Floyd, & Harrison Counties

1319 Duncan Avenue
Jeffersonville, IN 47130
812-283-2308
Fax 812-283-2309

Everyone's Safety is Our Concern

The Family Health Centers are committed to provide a safe environment for patients and employees. Patients have a responsibility to be considerate and cooperative in dealing with FHC staff and to respect the rights of other patients. Any form of violent behavior, including physical or verbal threats, harassment, intimidation, and other disruptive behavior on Family Health Center property will not be tolerated. Individuals who commit acts of aggression or violence may be removed from the premises and may be subject to disciplinary action, criminal penalties, or both. We need your help to keep the Family Health Centers safe. If you observe violent or disruptive behavior by anyone on the premises, report it immediately to the nearest staff person. All reports of incidents will be taken seriously and dealt with appropriately.

FAMILY HEALTH CENTERS OF SOUTHERN INDIANA

Notice of privacy practices Effective date of notice: April 13, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT *YOU* MAY BE USED AND DISCLOSED AND HOW *YOU* CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

GENERAL RULE

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. Generally, we may use your health information in our office or disclose it outside of our office without your written permission for the purpose of treatment, payment, or other health care operations. For most all other types of disclosure, we are required to obtain your permission. In some limited situations, the law allows or requires us to disclose your health information without your written authorization.

STANDARD USES OR DISCLOSURES

We use information for treatment purposes when, for example, we set up an appointment for you. We may disclose your health information outside of our office for treatment purposes if, for example, we refer you to another doctor or clinic for further care, if we send a prescription for filling. Sometimes we may ask for copies of your health information from another professional that you may have seen before us to allow us to treat you more efficiently.

We use your health information for payment purposes when, for example, our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services and when we try to collect unpaid amounts due. We may disclose your health information outside of our office for payment purposes when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or your health insurance plan.

We use and disclose your health information for health care operations in a number of ways. Health care operations refers to those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

USES AND DISCLOSURES WITHOUT CONSENT OR AUTHORIZATION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime; or to report a crime.
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures relating to worker's compensation programs;
- disclosures to business associates who perform health care operations for us and who agree to keep your health information private.

OTHER DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You

do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the HIPAA privacy officer.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the HIPPA privacy officer.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know received the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the HIPPA privacy officer

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the address at the end of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION write/call:

HIPPA/Privacy Officer for Family Health Center
1319 Duncan Avenue
Jeffersonville, IN 47130
(812)-283-2308

Everyone's Safety is Our Concern

The Family Health Centers are committed to provide a safe environment for patients and employees. Patients have a responsibility to be considerate and cooperative in dealing with FHC staff and to respect the rights of other patients. **Any form of violent behavior, including physical or verbal threats, harassment, intimidation, and other disruptive behavior on Family Health Center property will not be tolerated**. Individuals who commit acts of aggression or violence may be removed from the premises and may be subject to disciplinary action, criminal penalties, or both. We need your help to keep the Family Health Centers safe. If you observe violent or disruptive behavior by anyone on the premises, report it immediately to the nearest staff person. All reports of incidents will be taken seriously and dealt with appropriately.

Updated FHCSI August 2015