PATIENT INTAKE FORM

Account No: _____ Date: _____ Location: _____

PATIENT INFORMATION

FIRST: _____ **MIDDLE:** _____ **LAST:** _____ **SUFFIX:** _____

Date of Birth: _____ **Social Security Number:** _____

Address: _____ Apt.# ____ City _____ State _____ Zip _____

Mailing Address (if different): _____ Apt.# ____ City _____ State ____ Zip _____

Phone Number: Home: _____ Cell/Alternate: _____ Work: _____

Best Contact Number: ☐ Home ☐ Cell ☐ Work ☐ Alternate (If selected: owner of number: _____)

Email Address: _____

Employer Name: _____

Employer Address: _____

Your primary language? _____

Pharmacy of Choice: _____

Gender Identity: ☐ Male ☐ Female
☐ Transgender: Male/Female-to-Male
☐ Transgender: Female/Male-to-Female
☐ **Choose not to disclose** ☐ **Other**

Are you interested in getting **Discounted Prescriptions from Teche Health's Pharmacy**: ☐ Yes ☐ No

How did you hear about Teche: ☐TV Ad ☐ Radio ☐ Billboard ☐ Family/Friend ☐ Other: _____

EMERGENCY CONTACT: (To be contacted **only** in the event of an emergency. Please list someone **not** living with patient.)
Name: _____ Phone: _____ Relationship: _____ 18 or over: ☐ Yes ☐ No
Name: _____ Phone: _____ Relationship: _____ 18 or over: ☐ Yes ☐ No

FOR MINORS ONLY (if patient is under 18 years old):

Parent/Legal Guardian of Minor: _____ Date of Birth: _____
Address: _____ Relation to Minor: _____

Parent/Legal Guardian of Minor: _____ Date of Birth: _____
Address: _____ Relation to Minor: _____

I authorize other individual(s) to accompany my child to receive treatment at Teche Health in my absence.
☐ **Yes** *(complete **Absent Parent Consent** Form)* ☐ **No**

INSURANCE INFORMATION

☐ **I HAVE NO INSURANCE**

PRIMARY INSURANCE: _____
Policy ID#: _____
Policy Holder Name: _____
Date of Birth: _____

SECONDARY INSURANCE: _____
Policy ID #: _____
Policy Holder Name: _____
Date of Birth: _____

DENTAL INSURANCE: _____
Policy ID#: _____
Policy Holder Name: _____

MENTAL HEALTH INSURANCE: _____
Policy ID#: _____
Policy Holder Name: _____

SLIDING FEE DISCOUNT PROGRAM ELIGIBILITY

Your **household income and family size** may qualify you and your family for Teche Health's **Discount** on services. Our Patient Service Reps and Community Health Workers can assist you with any questions and how to apply.

Would you like to apply for a **SLIDING FEE DISCOUNT:** ☐ **Yes, I WOULD.** ☐ **NO, I DO NOT.**

Patient Name: _____ DOB/MR#: _____

SOCIO-ECONOMIC INFORMATION

NOTE: As a Federally Qualified Health Center, Federal Law requires Teche Health to collect the following information for **statistical** purposes only. Individual patient information is **NOT** reported or disclosed. The collection of this information also assists us in applying for grant funds to support and expand services. **Thank you for your cooperation**!

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many people live in your home, including you? _____

Approximate total *monthly* household income?

☐ No Income ☐ $1 - $1,000 ☐ $1,000-$1,499 ☐ $1,500-$1,999 ☐ $2,000-$2,499 ☐ $2,500-$2,999
☐ $3,000-$3,499 ☐ $3,500-$3,999 ☐ $4,000-$4,499 ☐ $4,500-$4,999 ☐ $5,000 +

Other Sources of Income (Mark all that apply)**:** ☐ SSI ☐ Veteran's Assistance ☐ AFDC/TANF ☐ Food Stamps
☐ Social Security ☐ Retirement Benefits ☐ Section 8 Housing ☐ Child Support

Are you a Veteran? ☐ Yes ☐ No **Are you a smoker?** ☐ Yes ☐ No **Sex Assigned at Birth: _____**

Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual
☐ Something else ☐ Don't Know ☐ Choose not to disclose

Are you living in public housing? *(Section 8 is not considered Public Housing)* ☐ Yes ☐ No

Are you experiencing homelessness? ☐ No ☐ Yes **If yes, check one:** ☐ Shelter ☐ Street ☐ Transitional
☐ Doubling Up (living with friends/family) ☐ Unknown (Decline to state) ☐ Other: _____

Ethnicity: Hispanic, Latino/a or Spanish? ☐ No ☐ Yes **(please specify)**: _____ ☐ Refuse to Report

Race: (Mark all that apply) ☐ African American/Black ☐ American Indian/Alaska Native ☐ Caucasian/White
☐ Asian: [please specify:☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese]
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other ☐ Refuse to Report

Are you a migrant? Have **you or an immediate family member** lived away from home in the last 2 years in order to work in any type of agriculture (farm work)? ☐ Yes ☐ No

Are you a seasonal worker? Have **you or an immediate family member** worked in any type of agriculture (farm work) in last 2 years- like planting, picking, preparing the soil, packing house, driving a truck for any type of farm work, working with animals like cows, chickens, etc.? ☐ Yes ☐ No

Did you or an immediate family member stop migrating to work in agriculture (farm work) because of a disability or age (too old to work)? ☐ Yes ☐ No

I have in-home WiFi? ☐ Yes ☐ No **My cell phone is an** ☐ Android ☐ iPhone

I have a federally funded phone? ☐ Yes ☐ No **I have a monthly data plan for my cell phone**? ☐ Yes ☐ No

Patient or Legal Guardian's Name (print): _____

Patient or Legal Guardian's Suignature: _____ Date: _____

Patient Name: _____

Teche Health staff should complete below if Acknowledgement & rights and Responsibilities Section is not signed.

Did the patient receive the Privacy Notice? ☐ YES ☐ NO Employee Initials: _____

DOB: _____

Integrated Health Care Consent to Treatment

Before you give your consent, be sure you understand the information given below.
We will be happy to answer any questions you have. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessa1y for my understanding of the written or spoken information given during my healthcare visits.

Consent for Treatment: I request Teche Health to provide **me (or my minor dependents)** with medical, dental, behavioral health (substance abuse, psychological, or psychiatric), and/or social care. I will be given information about the test(s), treatment(s), procedure(s), and medication(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I hereby request that a person authorized by Teche Health provide appropriate evaluation, testing, and treatment. As possible and practical, I will cooperate fully with the provider, adhering to the treatment regimen and screening procedures set fo1th. This consent is valid for services received from 1.1.2025 through 5.31.2026.

It is agreed that the practice of medicine is not an exact science. No guarantee can be made, real or implied, as to the result of services.

Right to Withdraw Consent: I have the right to withdraw my consent for treatment of myself and/or my child(ren) at any time by providing a written request to the treating provider.

Expiration to Consent: This consent will expire one year after from the date it is signed, unless otherwise specified.

Patient/Legal Guardian's Initials: _____ Date: _____

PATIENT ACHKNOWLEDGEMENTS AND CONSENTS

Patient Name: _____ Patient DOB: _____ Account No: _____

Date: _____ Location: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices,

I hereby acknowledge that I have received and reviewed a copy of Teche Health Notice of Privacy Practices, which explains how my protected health information may be used and disclosed. I understand that I have the right to request restrictions on certain uses and disclosures of my health information and can access a copy of my medical record.

Release of Information: I understand that confidentiality will be maintenance as described in the Privacy Notice. I consent to the use and disclosure of my health information described in the health information Privacy Notice. I understand that all services are confidential. However, In certain cases, such as life-threatening emergencies, abuse, reportable diseases, Teche Health may be required to share information when we make a referral to another agency. Also, information may be shared and reviewed for Quality Assurance purposes with State, Federal and private grantors as necessary.

By signing this form below, I acknowledge that Teche Health has given me a copy of the Notice of Privacy Practices, which explains how your health information will be handled in various situations and has given me the chance to discuss my concerns and questions about the privacy of my health information.

Patient/Legal Guardian's Initials: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF BILL OF RIGHTS and RESPONSIBILITIES

I hereby acknowledge that I have received a copy of the Patient's Bill of Rights and Responsibilities, which explains how Teche Health recognizes each patient as an individual with unique health care needs and, because of the importance of respecting each patient's person dignity, is committed to providing considerate, respectful care focused on the patient's individual needs. Teche Health assists the patient in the exercise of his/het rights and informs the patient of any responsibility he/she has in the exercising of these rights. All of these rights apply to persons who may have responsibility to make decisions regarding medical care on behalf of the patient.

Patient/Legal Guardian's Initials: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT ADVANCE HEALTH CARE DIRECTIVES INFORMATION

I hear by acknowledge that Teche Health has provided and discussed information with me regarding advanced healthcare directors' information. I understand that it is my responsibility to provide test health with any documents that are required to carry out, my advanced healthcare directives.

Patient/Legal Guardian's Initials: _____ Date: _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY AND CONSENT TO DISCLOSURE

Insurance Information: I hereby grant Teche Health permission to release medical and/or dental supporting documentation to my insurance company for services rendered to myself and/or covered dependents**. Assignment of Insurance Benefit:** I hereby authorize payment directly to Teche Health of benefits otherwise payable to me but not to exceed Teche Health's regular charges for this service. I understand that I am financially responsible to Teche Health for any charges not covered by my insurance, including the balance of my charges after any discount has been applied. **Acceptance of Responsibility for Co-Payments:** I understand that I am responsible for any health insurance deductibles or co-payments or any services that my insurance does not cover.

Motor Vehicle Accident and Worker's Compensation: I understand that I am 100% responsible for the bill for treatment for a motor vehicle accident or worker's compensation incident, and that I must pay the bill in full on the day treatment is rendered. I also understand that I may not have to pay for treatment rendered if written documentation is provided by my attorney or claim adjuster (representing a pending claim or lawsuit) promising to pay the account in full.

Financial Agreement: I agree to pay all charges that are not payable by insurance or third party. I agree to abide by the terms and conditions of Teche Health's Collections Policy. I understand that there may be additional costs for supplies and equipment related to, but not included in the co-pay, deductible or nominal fee collected at the time of service. I understand that I may receive a bill for such additional costs, in accordance with Teche Health's fee policy and that it is my obligation to pay such bills and that payment arrangements can be scheduled for any unpaid balances.

Teche Health is not a free clinic and failure to fulfill your fiscal responsibility to us or agree to a payment schedule may result in your financial discharge from our services. In accordance with Teche Health's Collections Policy, Teche Health may choose to terminate its relationship with any patient who does not comply with this financial agreement.

I hereby acknowledge receipt of Teche Health's Notice of Privacy Practices. I also agree to allow Teche Health to share demographic and income data with State, Federal and Private grantors as necessary. Any information provided that is discovered to be false now, or in the future, could be considered fraud for which I could be held liable.

Patient/Legal Guardian's Initials: _____ **Date**:_____

PATIENT COMMUNICATION CONSENT

The providers and others here at Teche Health want to do all we can to protect the health information we have about your health and keep it private and secure. You have a right to that information, and the right to talk to your healthcare team about it.

When we need to contact you, we will only speak to you, or people you have listed below. You should list only the numbers you wish us to use to contact you.

- I agree to allow Teche Health to contact me in the following methods regarding my private health information, evaluation, and treatment.

If I have checked "YES", I authorize Teche Health to leave messages for me when I am unavailable

It is in your best interest and in the best interest of Teche Health that **Behavioral Health** providers do not/will not communicate with any patients regarding their treatment or care via email and/or text. Nor will we initiate communication with you as a patient in this manner.

Home Phone _____ ☐ YES ☐ NO Cell Phone _____ ☐ YES ☐ NO

Work Phone _____ ☐ YES ☐NO Other Phone _____ ☐ YES ☐ NO

I authorize Teche Health and medical staff to discuss my/my child(ren) healthcare information (which may include history, diagnosis, labs, test results, treatments, and other health information) with the contacts listed below. I understand that by leaving spaces blank, I am indicating my choice to be "No Information," and I do not want any information released without my express consent.

Name:	**Relationship to Patient:**	**Contact Info:**

By my signature below I acknowledge that I have read and understand the information provided in this form above and authorize services by Teche Health as the patient or as the patient's general agent and accept its terms. I understand the risk associated with the different methods of communication, restrictions, and the patient responsibilities outlined above as well as any other instruction that Teche Health may impose.

I understand that I will be required to update this information at least annually or when my information changes, whichever occurs first.

By signing below I'm stating that the information I have provided is true**,** and I authorize Teche Health to verify that information, and release it to referring/mutual providers of care.

Patient or Legal Guardian Signature: _____Date: _____

Witness _____Date: _____