PATIENT INTAKE FORM

Account No.: _____ Date:_____

Location: _____

PATIENT INFORMATION

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

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

Address: _____ Apt. _City _____ State _Zip_____

Mailing Address: _____ Apt. _City _____ State _Zip_____

Phone Number: Home _____ Cell/Alternate _____ Work_____

Best phone number for contact: ☐ Home ☐ Cell ☐ Work ☐ Alternate (If "Alternate" applies, whose phone number is this?)_____

☐ Confidential/Speak Only to Me ☐ Do Not Call

Email Address: _____

Employer Name: _____

Employer Address: _____

_____

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

Pharmacy of Choice: _____ **Referred By:** ☐Advertising ☐ Family/Friend ☐ Other:_____

Head of the household: First & Last Name: _____ Relationship : _____ Gender: ___

DOB: _____Phone Number: _____

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

EMERGENY 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

SOCIO-ECONOMIC INFORMATION

NOTE: As a Federally Qualified Health Center, Federal Law requires Teche Action Clinic (TAC) to collect the following information for statistical purposes only. This information is reported annually on a total patient basis. Individual patient information is NOT reported or disclosed. The collection of this information also assists TAC in applying for additional grant funds to support and expand its services. **Thank you for your cooperation**.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Are you a Veteran?** ☐ Yes ☐ No

What is your primary language?_____ **Smoker?** ☐ Yes ☐ No **Sex Assigned at Birth:** _____

Patient Sexual Orientation: ☐ Heterosexual/Straight (not lesbian or gay) ☐ Lesbian or 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

How many people live in your home? _____ **Approximate *monthly* household income?**

☐ Under $1,000 ☐ $1,000-$1,500 ☐ $1,500-$2,000 ☐ $2,000-$2,500 ☐ $2,500-$3,000
☐ $3,000-$3,500 ☐ $3, 500-$4, 000 ☐ $4,000-$4,500 ☐ $4,500-$5,000 ☐ $5,000-$5,500 ☐ Over $5,500

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

Patient Name: _____ DOB: _____

SOCIO-ECONOMIC INFORMATION (CONT.)

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

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

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

Are you a seasonal worker? In the last 2 years have **you or an immediate family member** worked in any type of agriculture (farm work) - 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

Do you lack permanent housing (Are you experiencing homelessness)? ☐ Yes ☐ No

If yes, check one: ☐ Doubling Up (living with friends or family) ☐ Homeless Shelter ☐ Street ☐ Transitional ☐ Unknown (Decline to state) ☐ Other _____

FINANCIAL INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

Policy ID (Insurance #): _____

Policy Holder Name: _____ Date of Birth: _____

SECONDARY INSURANCE COMPANY NAME: _____

Policy ID (Insurance) # _____

Policy Holder Name: _____ Date of Birth: _____

DENTAL INSURANCE COMPANY NAME: _____

Policy ID (Insurance) # _____

Policy Holder Name: _____ Date of Birth: _____

MENTAL HEALTH INSURANCE COMPANY NAME: _____

Policy ID (Insurance) # _____

Policy Holder Name: _____ Date of Birth: _____

☐ **I HAVE NO INSURANCE.**

☐ **I WOULD LIKE TO APPLY FOR A SLIDING FEE DISCOUNT**

Your **household income and family size** may qualify you and your family for Teche Action Clinic's **Sliding Fee Discount** Program. Our Patient Care Navigators and Community Health Workers can assist you with any questions and how to apply**.**

Insurance Information: I herby grant TAC 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 TAC of benefits otherwise payable to me but not to exceed TAC's regular charges for this service. I understand that I am financially responsible to TAC 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 TAC'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 TAC'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 Action Clinic 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 TAC's' Collections Policy, TAC may choose to terminate its relationship with any patient who does not comply with this financial agreement.

I hereby acknowledge receipt of Teche Action Clinic's Notice of Health Information Privacy Practices. I also agree to allow TAC 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**:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
BILL OF RIGHTS and RESPONSIBILITIES and LIVING WILLS/ADVANCE DIRECTIVES

Release of Information: I understand that confidentiality will be maintained as described in the *Privacy Notice*. I consent to the use and disclosure of my health information as 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, TAC 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 Action Clinic has given me a copy of the Notice of Privacy Practices, which explains how your health information will be handled in various situations.

☐ I have reviewed Teche Action Clinic's ***Notice of Privacy Practices and Patient's Bill of Rights and Responsibilities***.

☐Teche Action Clinic has given me the chance to discuss my concerns and questions about the privacy of my health information.

☐ I have received information from Teche Action Clinic's regarding ***Living Wills and Advanced Directives***.

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

Teche Action Clinic's staff should complete below if Acknowledgement & Rights and Responsibilities Section is not signed.

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

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 necessary for my understanding of the written or spoken information given during my healthcare visits.

Consent for Treatment: I request Teche Action Clinic (TAC) to provide **me (or my minor depdendants)** 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 Action Clinic 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 forth.

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 12 months from the date of signature, unless otherwise specified.

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

Patient Name: _____ DOB: _____

PATIENT COMMUNICATION CONSENT

The providers and others here at Teche Action Clinic (TAC) 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 TAC to contact me in the following methods regarding my private health information, evaluation and treatment.
- If I have checked "YES", I authorize TAC to leave messages for me when I am unavailable.

It is in your best interest and in the best interest of TAC 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 to 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 TAC 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 Action Clinic 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, and consent to the conditions, restrictions, and the patient responsibilities outlined above as well as any other instruction that TAC 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 TAC to verify that information, and release it to referring/mutual providers of care.

Patient or Legal Guardian Signature: _____Date: _____

Witness _____Date: _____