

PATIENT INFORMATION

DATE: _____

Full Legal Name: _____
First Middle Initial Last

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Sex: Male _____ Female _____ Marital Status: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

E-mail Address: _____

EMERGENCY CONTACT

In case of emergency, whom should we notify? _____
First Middle Initial Last

Relationship to emergency contact: _____ Phone Number: _____

We are required to request the following information for federal funding.

- RACE**
- American Indian/Alaskan
 - Asian
 - Black/African American
 - Native Hawaiian
 - Another Pacific Islander
 - White

- ETHNICITY**
- Hispanic/Latino
 - Not Hispanic/Latino

- Housing Status**
- Not Homeless
 - Shelter
 - Street
 - Doubling Up
 - Transitional
 - Other

- GENDER IDENTITY**
- Male
 - Female
 - Male to Female
 - Female to Male
 - Gender Neutral
 - Declined to Specify
 - Other

- Sexual Orientation**
- Heterosexual
 - Gay, Lesbian or Homosexual
 - Bisexual
 - Something Else
 - Don't Know
 - Declined to Specify

- Sex at Birth**
- Male
 - Female
 - Unknown
 - Declined to Specify

Have you or has anyone in your household worked in agriculture, such as planting, cultivating, or harvesting agriculture products (fruits, vegetables, grains, or dairy) in the last two years? Yes No

Are you a veteran? Yes No

Do you need an interpreter? Yes No If yes, what language? _____

Health Partnership Clinic (HPC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. HPC provides free language services to people whose primary language is not English such as qualified interpreters and information written in other languages. (HHS part 92 of section 1557)

PHARMACY

If prescribed medication, what pharmacy should we send the prescription?

Pharmacy: _____
Name/Address/Phone Number

RESPONSIBLE FINANCIAL PARTY (if patient is under 18 years of age)

Full Legal Name: _____
Last Middle Initial First

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship to Patient: _____ E-mail Address: _____

INSURANCE INFORMATION

___ I am currently not insured.

___ I am currently not insured, but currently working or have worked in agriculture/farm work in the last two years.

___ I am currently insured (Please complete the information below).

Primary Insurance (Provide a copy of your insurance card(s) to registration personnel.)

Subscriber's Name: _____ Subscriber's Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

Name of Insurance Company: _____ Group Number: _____

Policy or Identification Number: _____

Secondary Insurance (Provide a copy of your insurance card(s) to registration personnel.)

Subscriber's Name: _____ Subscriber's Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

Name of Insurance Company: _____ Group Number: _____

Policy or Identification Number: _____



PROTECTED HEALTH INFORMATION

The undersigned acknowledges receipt of the Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. I hereby authorize the verbal release of my Protected Health Information for discussion of my care, treatment, and/or payment to the person(s) specified below. (45CFR 164.502(F) & 164.502 (G))

Please list any other parties who can have access to your health information:

1. _____
Name Relationship Phone
2. _____
Name Relationship Phone
3. _____
Name Relationship Phone

Confidentiality: I am aware that information about my treatment is considered confidential and will be used in a manner consistent with proper professional conduct and will only be released to outside sources under applicable state and federal law statutes and regulations or when ordered by a court of competent jurisdiction.

Health Information Exchange

Health Partnership Clinic participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization (HIO) to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at <http://www.KanHIT.org>, or by completing and mailing a form. This form is available at <http://www.KanHIT.org>. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIOs, please [visit http://www.KanHIT.org](http://www.KanHIT.org) for additional information.

Patient/Legal guardian Signature Date _____



APPOINTMENT POLICY

The demand for Health Partnership Clinic services are much greater than the number of appointment time slots we have available. This makes it very important that our patients keep their appointments

If you cannot keep your appointment, you must call at least 24 hours ahead of time so another patient can be seen in your appointment slot. If you are 10 minutes late for an appointment, it could be considered a missed appointment.

If you do not show up for your appointment and do not cancel 24 hours before, you will be considered a NO SHOW. Once you reach three no showed appointments, you will be considered for dismissal from the clinic.

CONSENT FOR TREATMENT

Health Partnership Clinic (HPC) is dedicated to providing primary care, dental care and mental health services. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. HPC patients may be referred to providers from other health care specialties within the HPC treatment team. Members of the treatment team will share clinical information with each other as is clinically necessary.

I understand HPC reserves the right to limit or dismiss any individual from accessing HPC services. Such limitations may result for reasons including, but not limited to, failure to provide 24 hours notice of appointment cancellation, disruptive or abusive behavior, refusal to follow recommended healthcare treatment, and fraud.

I understand that HPC is approved to train students. I also understand students may observe or participate in patient care. I permit such involvement, unless I notify HPC to the contrary in writing, with the understanding that the student's work will be under the supervision of a qualified instructor or staff of HPC.

While a patient of HPC, I hereby consent to care and treatment, including but not limited to diagnostics, therapeutic testing and treatment as may be deemed necessary or advisable by my care provider, his/her associates, or designees which may be advisable and necessary based on his/her knowledge and my health condition. I understand that no guarantees have been made to me about the outcome of this care. **Services provided in addition to the original scheduled appointment, may result in higher fee for service than quoted.** _____ Initial for acknowledgment.

FINANCIAL INFORMATION

Financial Agreement: I hereby assign to Health Partnership Clinic, any and all benefits payable from any policy of insurance covering the patient or person responsible for the patient's care (including but not limited to Medicare, Medicaid, commercial insurance policies, etc.) to be paid directly to HPC to be applied to the charges for services rendered. I understand I am responsible for fee at time of service, co-insurance payments, deductibles and/or any remaining balance. In the event pre-certification for such treatment is required by any health plan or insurance policy, the patient or agent is responsible for obtaining such pre-certification

Medicare/Medicaid: The patient or agent affirms that the information provided in applying for payment under Social Security Act Title XVIII (Medicare), State Medicaid laws or any other federal or state Social Security Act Title XVIII program is correct and authorizes HPC, or its employees or agents to provide medical or other information necessary for processing a claim to any government agency or their intermediaries or insurance carriers. Request is hereby made for payment of authorized benefits on patient's behalf.

Medicare Non-Covered Service: I understand that Medicare does not pay for some services that I am fully responsible for payment of this service.

It may be necessary to restrict access to patients who, after all efforts have been exhausted, fail to fulfill their financial responsibilities to HPC. Patient files could be flagged to this effect and appointments not accepted in cases of consistent non-payment & you will be considered for dismissal from the clinic.

Patient/Legal Guardian Signature

Date