Family Care Health Centers

New/Established Patient Information

(Please Print) ***Account # _____***

Date: _____ **Circle One:** New Patient or Established Patient

Last:_____First:_____ M.I._____ Date of Birth: _____
Address:_____City: _____ State:_____ Zip: _____
Home Phone:_____Work Phone:_____ Cell Phone: _____
Social Security#:_____ e-mail:_____

Emergency Contact: Name:_____ Relationship:_____
Home Phone:_____ Cell Phone:_____

Sex: ☐ M ☐ F

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Legally Separated
☐ Unknown

Race:
☐ Asian
☐ American Indian / Alaskan Native
☐ Black / African American
☐ More Than One Race
☐ Native Hawaiian
☐ Pacific Islander
☐ Unreported / Refused to Report
☐ White

Language: ☐ English ☐ Language:_____

Employment:
☐ Employed
☐ Self Employed
☐ Unemployed
☐ Disabled
☐ Retired
☐ Part-time Student
☐ Full-time Student

Ethnicity:
☐ Latino / Hispanic
☐ Non-Latino / Hispanic
☐ Unreported / Refused to report

Employer Name:_____
Address: _____
City/State/Zip _____

Do you have a Legal guardian or a health care proxy: ☐ Yes ☐ No
(An individual designated by the patient, court or family to make health care decisions for you.)

Do you have a Primary Caregiver: ☐ Yes ☐ No
(An individual who provides day-to-day care for you and receives instructions about providing that care.)

Occupation: _____
(Are you a nurse, welder, in food service, banker, media, or other)

Advance Directives: ☐ None / Declined ☐ Yes (select advance directive and provide a copy to FCHC)

☐ Living Will
☐ Do not Resuscitate
☐ Power of Attorney

Homeless: ☐ Yes ☐ No Work status: ☐ Migrant ☐ Seasonal ☐ Not Migrant / Seasonal
Public Housing: ☐ Yes ☐ No Veteran: ☐ Yes ☐ No

Initial

(Over >>>)

Please list all family members (Please PRINT):

Name	D.O.B.	Relationship	Name	D.O.B.	Relationship
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.			14.		

Patients with Medicaid, Medicare, or Private Insurance(s), please complete the following information.

	Primary	Secondary	Dental
Name of policy holder	_____	_____	_____
Policy holder birth date	_____	_____	_____
Policyholder Social Security No.	_____	_____	_____
Name of Insurance Carrier	_____	_____	_____

Patient's relationship to policyholder (Circle One): Self Child Spouse Other_____

Are you a Family Planning patient at Family Care Health Centers? Yes No
If yes, may we contact you at the above address/telephone? Yes No If no, please tell us where we may contact you or leave a message. _____

I understand I may be tested for sexually transmitted infections, including HIV. Positive tests will be reported to the State of Missouri, as required by law.

☐ I do not want the HIV test.

Consent

I authorize my physician and other physician(s)/dentist(s) who may attend me, their associates and assistants and Family Care Health Centers (hereinafter referred to as "Health Center"), its house staff, employees, agents and students to provide the medical/dental care, dental x-rays, tests, procedures, drugs, services and supplies considered advisable by my physician(s)/dentist(s). These services may include a review of my medical history, physical/dental examination, and appropriate lab and health screening tests. I agree to accept responsibility for any additional and/or follow up care that may not be available at this health center. In consenting to treatment, I have not relied on any statements as to results.

_____
Initial

(Over >>>)

Storage and Release of Information

I consent to the electronic storage and transmission of patient health information. I hereby authorize the Health Center and its associates, my treating physicians to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

a) The health professionals involved or who may be involved in my care either at hospital or following hospitalization;
b) The person or entity responsible or who may be responsible to pay for any or all of my care rendered by the Health Center or on behalf of the Health Center;
c) Any government or other entity as required by law for purposes of reporting or for purposes of determining eligibility in government sponsored benefit programs;
d) Health Center personnel who perform activities or evaluate the health or other services that the Health Center or other health professional may provide, including but not limited to, case management, accreditation surveys or clinical reviews;
e) Any continuing care, residential or long-term care facility or home health agency for the purpose of providing services for my care.

Medicare Insurance Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its intermediaries or carriers concerning this or a related claim filed by the Health Center. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered charges.

Photographs, Film or Digital Recording

I understand that photographs, film or digital recordings may be taken of me during my care for purposes of identification, record-keeping, diagnosis and/or treatment of me. Any such photographs or recordings will be maintained as part of my private health information and may only be used for the purposes listed above. Unless required by law, any other use or release of photographs, film or digital recordings of me requires my written consent.

Guarantee for Payment

In accordance with the above terms and in consideration of the services provided to the above-named patient by the Health Center, the undersigned agrees, whether he/she signs as patient or guarantor, to pay the Health Center for all services ordered by the attending physician, the patient and the patient's family. (Including laboratory services furnished by an independent contractor and is not employees or agents of the Health Center. Consequently, I understand that I may receive a separate bill for their services.) If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payor, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

Assignment of Insurance

In consideration of any and all medical services, care, drugs, supplies and equipment furnished by the Health Center, I authorize direct payment to the Health Center of all insurance benefits applicable to this care, which are now or which shall become due and payable to me. In addition, I hereby authorize direct payment to the Health Center of all insurance benefits applicable to medical and/or other services rendered by physicians for who the Health Center is authorized to charge or bill.

Office Visit Co-payments

I understand that a minimum payment is due at time of service. I understand that the health center accepts assignment from Medicare, Medicaid or insurance companies, but that **I am responsible for my deductible, co-insurance and or any self pay-sliding fee amounts is ultimately my responsibility.** If I have a HMO/PPO Medicaid, Medicare or any other medical insurance I am responsible for presenting my insurance card(s) at each visit or I will be responsible for all charges incurred **including but not limited to deductible, co-insurance and or any self pay-sliding fee amounts is ultimately my responsibility.**

Consent to Share Information
St. Louis Integrated Health Network
Health Information Exchange (HIE)

General Consent

I understand and agree that my health information may be stored in or exchanged through one or more electronic health information exchanges through which health care professionals and facilities and others involved in my care may view and obtain my information. I also understand and agree that, once my health information is exchanged in that way, it may be added into other treating providers' medical records, and may be aggregated with the health information of others and used or disclosed to conduct data analysis, or for any other lawful purpose.

Consent for Release of Sensitive Information

I understand and agree that my health care providers may collect or maintain health information related to any of the following: mental health or developmental disability treatment, alcohol or drug abuse treatment program services, HIV/AIDS testing or other communicable diseases, head trauma and brain injuries, genetic testing/counseling, sexual assault or artificial insemination (any or all of which are "Sensitive Information.") I specifically consent to the disclosure or receipt of such Sensitive Information for the purposes described above in the Consent for Sharing of Information via Health Information Exchanges. I have the right to inspect and copy any of my mental health or developmental disability information that will be shared.

Duration of HIE Consent

I understand that this HIE Consent applies to information generated prior to the date of this HIE Consent and during any subsequent visit while this Consent is in effect. This HIE Consent is effective on the date of my signature (or the signature of my authorized representative below) below. The Consent for Release of Sensitive Information expires with respect to information about mental health and developmental disability services [**25**] years after the signature date on this HIE Consent. I may revoke this HIE Consent in writing, at any time; provided, however, that such revocation will not apply to any uses or sharing of my health information that occurred prior to the date the written revocation was received.

Please legibly sign that you have read, understand and acknowledge all of the above.

The undersigned certifies that the conditions of services have been read and are understood. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute these conditions of services and accept the terms thereof.

Patient/Parent/Legal Guardian Name (print)

Patient/Parent/Legal Guardian (signature) **Date**

Telephone Number

How did you find out about Family Care Health Center (FCHC)? **Check all that apply**:

____ Neighbor, Relative, Friend	_____ FCHC Staff	____ Brochure
____ Community Agency	_____ Outreach Worker	____ Flyer/Poster
____ Social Services	_____ Private Physician	____ Newspaper
____ School	_____ Hospital	____ Radio
____ Church	_____ Health Organization	____ Television
____ Health Fair	_____ Street Pole Banner	____ Billboard

____ Other (please specify): _____