PATIENT INFORMATION

NEW Patients: Please complete the entire form, sign, and date.
ANNUAL UPDATE: Please complete the gray sections (front of the form), sign, and date on the back.

PATIENT'S PERSONAL INFORMATION:

First Name: _____ Middle Initial: ____ Last Name: _____

Mailing Address: _____ Apt/Unit: _____

City: _____ State: ____ Zip: _____ E-mail Address: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: ____/____/_____ Social Security #: _____
MM DD YYYY

Preferred method of communication: ☐ Voice ☐ Text ☐ Both

Emergency Contact: _____ Relationship: _____ Phone: _____

Pharmacy: _____ **Location:** _____

What is your medical insurance?

☐ None/Uninsured ☐ Medicaid ☐ Private Insurance ☐ Medicare ☐ Other: _____

Name of insured: _____ Date of Birth: ____/____/_____
MM DD YYYY

What is your dental insurance?

☐ None/Uninsured ☐ Medicaid ☐ Private Insurance ☐ Medicare ☐ Other: _____

Name of insured: _____ Date of Birth: ____/____/_____
MM DD YYYY

HOUSEHOLD INCOME

Household Size	Annual Income less than or equal to
1	$30,120
2	$40,880
3	$51,640
4	$62,400
5	$73,160
6	$83,920
7	$94,680

Falls Community Health receives a Federal Grant that allows us to provide discounted fees to patients who qualify based on their household size and income. We are required to collect income information on the patients we serve. We respect that this information is personal and confidential.

How many people live in your household? _____

What is your annual HOUSEHOLD income? $ _____

If your income is less than the income identified in the table for your household size, please ask about our sliding fee program.

What is your current housing situation?

☐ I have a home (own or rent/lease apartment or house)
☐ I do not have a home, I stay at:
☐ Shelter ☐ Street ☐ Doubling Up/Couch-Surfing
☐ Transitional/Halfway House ☐ Other: _____

Please complete and sign back of form →

What is your sex assigned at birth?
❑ Male ❑ Female

What is your sexual orientation?
❑ Straight ❑ Gay or Lesbian
❑ Bisexual ❑ Don't Know
❑ Other ❑ Unknown
❑ Choose not to disclose

What is your gender identity?
❑ Female
❑ Male
❑ Transgender Female to Male
❑ Transgender Male to Female
❑ Choose not to disclose

Are you a Veteran:
❑ Yes ❑ No

Are you a:
❑ Migrant ❑ Seasonal Worker

What is your preferred language?
❑ English ❑ Other: _____

Ethnicity:
❑ Hispanic or Latino ❑ Non-Hispanic or Latino
❑ Chicano ❑ Cuban
❑ Mexican American ❑ Puerto Rican

Race
❑ American Indian or Alaskan Native
❑ Asian Indian
❑ Black/African American
❑ Chinese
❑ Filipino
❑ Guamanian or Chamorro
❑ Japanese
❑ Korean
❑ Native Hawaiian or Other Pacific Islander
❑ Samoan
❑ Vietnamese
❑ White
❑ Choose not to disclose

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF PAYER BENEFITS
I agree that I am financially responsible for all charges related to services provided by Falls Community Health (FCH). Further, if I am provided health care services by a provider other than FCH, while a patient within FCH, I am financially responsible for all charges related to services provided by said provider. FCH billing statements will not include charges by health care providers independent of FCH. I agree that FCH will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan, or insurance policy that I have or another third party that will pay the charges I have incurred. I give my authorization for FCH to file a claim request for direct payment of benefits to FCH.

Consent to Treat
I consent to exams, treatment, diagnostic tests, and medications that any provider at FCH feels is necessary for the health of me or my child.
I acknowledge that no guarantees have been made to me and I am aware that I have the right to ask my provider or nurse questions regarding my treatment or exam. Some services may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, accessible via the internet or saved in any way.
I authorize FCH to disclose my confidential information only for treatment, payment, or health care operations.

Consent to Obtain External Prescription History
I consent to provide FCH access and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes. I understand that my prescription history from other medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back several years. I acknowledge that FCH may use health information exchange systems to electronically transmit, receive, and/or access my prescription history.

Patient Grievance Patient inquiry/concern forms are available in waiting rooms or upon request.
Notice of Privacy Practices I have been offered a copy of this office's Notice of Privacy Practices.

Authorization:

_____ _____ _____
Signature of Patient/Responsible Party | Print Name | Date

Responsible Party (if patient not signing):

Relationship to Patient: _____ Date of Birth: _____/_____/_____ Social Security Number: _____
mm dd yyyy