Family Health Centers of Southern Indiana

New Patient Application

*You will need to supply proof of household income for all those living in the home in addition to proof of residency. Acceptable proofs include:

-A month's worth of paycheck stubs (or a written statement on employer's letterhead stating pay and hours worked), or a Medicaid/ government income verification letter

- Previous year federal tax return (1040 or other)

- A current utility bill, insurance bill, bank statement, government mail, rent payment receipt, etc.

-Driver License and Pay check stubs will not be accepted as proof of residency-

**If you have Insurance you are not required to provide proofs. However, this information is very important to the funding we receive that keeps our doors open and able to serve you and our community. Also, in the occurrence you may have a lapsed in coverage you may qualify and utilize our sliding fee discounts. **

-All visits require a nominal fee of at least $15. When you turn in your packet please ask the receptionist about what your fee will be. Thank You.

-You may incur additional fees depending on purpose of visit

-We accept Cash, Check, Credit/Debit (NO AMERICAN EXPRESS)-

Late Policy

All patients will be given up to 5 minutes grace to arrive for their scheduled appointment. If you arrive later then the allotted 5 minutes YOU WILL NEED TO RESCHEDULE, this appointment will also be considered and documented as a No-Show. If you get to 4 No-Shows (this includes less than 24hr cancellations) for any of the Health Centers departments or locations independently or combined YOU WILL BE DISCHARGED from the practice.

Patient Information

Patient's Name ______________________________ Date of Birth______________ Age_____

Social Security #____________________ Occupation___________________________

Address____ Apt#_______

City _________________________ State__________________ Zip Code ____________

Please check if any apply:

- Living with a friend
- Living on street
- Living in public housing
- Living in Shelter

Home Phone (____) _____________________ Cell Phone (____) ________________

Work Phone (_____) _____________________ Email_____________________________

- You give us permission to leave messages about test results, appointments, or other medical follow-up
- You give us permission to text Cell Phone **Y / N** Other Phone **Y / N**

Do you have a living will? **Y / N** (if yes please bring copy)

Do you have a guardian **Y / N** (If yes, name and phone number please ______________________________)

Are you a Veteran **Y / N** (If yes please circle one : Discharged/ retired/ active/reserve)

RACE– Black/African American, White/European American, Multi-racial, Native Hawaiian, Other Pacific Islander, Asian, Native American, Alaska native

ETHNICITY- Hispanic/ Non- Hispanic

PRIMARY LANGUAGE SPOKEN- English, Spanish, Arabic, Mongolian, Chinese, Japanese, Other:___________

PREFERRED LANGUAGE-___________________

MARITAL STATUS- Single, Married, Divorced, Widowed, Legally Separated, Domestic partnership

HIGHEST LEVEL OF EDUCATION MET- less than H.S., GED, H.S. Diploma, Some College, College degree

SEXUAL ORIENTATION- Hetero/straight, Gay, Bisexual, Other, Unknown, choose not to disclose

GENDER IDENTIFIED AS- Male, Female, Trans male, Trans female, Queer, other, choose not to disclose

INSURANCE

Primary Insurance Company: ____________________________ Policy Number___________________

Subscriber (If other than patient) ____________________ Subscriber's D.O.B__________ Relationship______

Secondary Insurance Company: __________________________ Policy Number___________________

Subscriber (if other than patient) ____________________Subscriber's D.O.B.__________ Relationship______

EMERGENCY CONTACT (NOT LIVING WITH YOU)

Name_______________________ Phone____________ Relationship______________

Address_______________________________ City____________ State_________ Zip Code_________

Consent to Release Information

Today's Date_______________

PLEASE READ IN FULL AND COMPLETE

Name: ____________________________ **D.O.B.** ______________________

I, Authorize the Family Health Centers of Southern Indiana to release or disclose my protected healthcare information or records over the phone, by mail, or via fax for the purpose of treatment, payment, and healthcare operations to the designated persons listed below. Before signing this consent, we encourage you to read our Notice of Privacy Practices in full. You have the right to request a copy and request how we are to disclose your information. We are bound by this agreement.

Name of Person/ Organization	Relationship	Phone/ Fax Number
____________________	____________________	(___)__________
____________________	____________________	(___)__________
____________________	____________________	(___)__________
____________________	____________________	(___)__________

Please Indicate one, both or all

- o **Medical**
- o **Behavioral Health**
- o **Chiropractic**

Acknowledgement of Receipt of Notice of Privacy Practices

- o I acknowledge that I have received or read a copy of Family Health Centers of Southern Indiana's NOTICE OF PRIVACY PRACTICES.

______________________________ ______________

(Client/Parent or Guardian Signature) (Date)

- o Client was offered NOTICE OF PRIVACY PRACTICES but refused to accept.

______________________________ ______________

(Clinician Signature) (Date)

- o Client was not offered NOTICE OF PRIVACY PRACTICES, for the following reason:

____

______________________________ ______________

(Clinician Signature) (Date)

FAMILY HEALTH CENTERS OF SOUTHERN INDIANA

Narcotic Agreement

1. Only the provider who is following your care or a partner in his/her practice may prescribe narcotics or other controlled substances for you.
2. Your provider will abide by all State and Federal laws regarding the prescription of narcotics and other controlled substances.
3. If you do not comply with the term s of this agreement, your provider will not prescribe narcotics or controlled substances for you and you provider may terminate your care. You will be notified in writing of any termination and given thirty (30) days to find another provider. During these thirty days, your provider will continue to furnish care for you only in emergencies.

PREFERRED PHARMACY MUST BE CHOSEN

____

(Pharmacy Name) (Pharmacy Location)

By signing below, I indicate that I agree to the conditions noted above. **I understand that violation of the agreement may result in my provider no longer providing prescriptions for narcotics or other controlled substances.** It could also potentially lead to prosecution through the legal system.

________________________________ ________________

(Patient Signature) (DATE)

CONSENT FOR TREATMENT

I herby give permission for myself/child ____________________, to receive medical treatment by the Family Health Centers of Southern Indiana, Inc. I understand that my responsibility in accepting treatment by the Center and/or referred physicians include compliance with follow-ups visits, prescribed test and the correct use of prescribed medications.

No one will be turned away for service. Patients may request sliding fee scale if they are within 200% of federal Poverty guidelines and residents of Clark County. **Fees are due at the time of service.** Arrangements may be made for delayed payment if requested.

________________________________ ________________

Signature Date

________________________________ ________________

Witness Date

CONSENT FOR TREATMENT IS EFFECTIVE FOR ONE YEAR AFTER THE ABOVE DATE

Updated and revised June 2020

Medical History Form

Please list provider's name if you have a preference_________________________ Date_______________

Patient's Name_________________________________ Date of Birth__________________

*If completed by other than patient please provide name and relationship_________________/_______

Please answer these questions as best as you can. We want to know your needs so we can provide the best possible care. Please check the answer that is right for you, "Yes", "No", "Fam" Family member". All answers are confidential and for our records only.

Medical

Yes No

Has there been a major change in health within the past year?............ ☐ ☐
If Yes, Please explain: ______________________

Are Immunizations Current?............ ☐ ☐

ALLERGIES to food/ medications?............ ☐ ☐
If Yes, Please note: ______________________

Are you under care of any other physician?............ ☐ ☐
Is Yes: Physicians Name ______________________
Reason for care______________________

Any Hospitalizations/ Serious illnesses?............ ☐ ☐
If Yes, explain:______________________
____

Any surgeries in past 3 years?............ ☐ ☐
If Yes, what______________________
When/Where (__/__/__) ______________________

Any artificial joints, valves, implants or prosthesis .... ☐ ☐
If yes. ______________________

Medications Y ☐ N ☐

Name	Dosage	Taken For

Patient/ Family Medical History

	Yes	No	Fam
Speech Problems	☐	☐	☐
Epilepsy	☐	☐	☐
Eating Problems	☐	☐	☐
Tuberculosis	☐	☐	☐
Visual Problems	☐	☐	☐
Heart Trouble	☐	☐	☐
Special Diet	☐	☐	☐
AID/ HIV	☐	☐	☐
Diabetes	☐	☐	☐
Respiratpry Problems	☐	☐	☐
High Blood Pressure	☐	☐	☐
Pychological Problems	☐	☐	☐
Cancer	☐	☐	☐
Bowel Problems	☐	☐	☐
Arthritis	☐	☐	☐
Hearing Problems	☐	☐	☐
Bladder Problems	☐	☐	☐
Alcohol use	☐	☐	☐
If Yes how many cups daily	1-3 ☐	3-5 ☐	>5 ☐
Smoker	☐	☐	☐
Packs per day	<1 ☐	2-3 ☐	Unk ☐
Breast Diseases	☐	☐	☐
Substance Abuse	☐	☐	☐

Children Only (have you had)

Measles Y/ N	Asthma Y/ N
Mumps Y/ N	Tonsillitis Y/N
Chicken Pox Y/ N	Excessive Colds Y/ N
Scarlet Fever Y/N	Ear Infections Y/ N
Jaundice Y/ N	Premature Y /N

Updated and revised June 2020

FAMILY HEALTH CENTERS OF SOUTHERN INDIANA

Acknowledgement of Financial Obligation

In the event that you are in need of labs and/or tests you will be referred to an area hospital (Clark, Floyd or Harrison), based on the county you live in. Each hospital determines the fees (if any) they will charge you. Any payment arrangement must be made between you and the hospital. It is recommended that you speak with each hospital **before** you obtain your labs, services and/or test. If you fail to call the number listed on your bill from the hospital, within the designated time period, you may be turned over to the Hospital's Collections Department. At that point you will ***no longer be eligible for a discount.***

Contact numbers for all hospitals:

Clark- (812) 283-2337

Floyd- (812)-949-5860

Harrison-(812)-738-7846 (requires a financial assistance application to be filled out as well)

The Family Health Center DOES NOT pay any medical bills for our patients

I agree to be referred to an area hospital for labs, services and/or tests:

YES _____ NO_____

I verify that I have read this document and that I fully understand the terms of the agreement

Signature: ______________________________ Date:________________________

Printed Name: ___________________________

Acknowledgement of Referral

If any point you are referred to a specialist for medical care, the specialist's office determines what fees (if any) they will charge you. Any Payment arrangement must be made between you and the specialist's office. It is recommended that you speak with the specialist's office billing department before your appointment to understand any fees that you may be charged.

Care or services received from any providers that are not staff at the Family Health Centers of Southern Indiana is beyond our control. When you see a specialist, you are entering into an agreement with that office.

The Family Health Centers of Southern Indiana do NOT pay any medical bills for our patients

Failure to keep an appointment or to cancel an appointment with the specialist may result in charges to you from that physician. Failure to call and cancel or reschedule within twenty-four hours of your appointment may jeopardize your ability to seek future care from the specialist.

I understand the terms of this agreement

Signature:__________________________ **Date:**__________________

Printed Name:_______________________

I understand the terms of this agreement, but choose not to be referred

Signature:__________________________ **Date:**__________________

Printed Name:_________________________

FINANCIAL INTAKE FORM

Date: ______________

Including yourself, how many people live in the home? ________

(Do not include anyone who pays you a fee to live in the home such as a roommate)

Complete the following for each member of your household. ***(INCLUDE YOURSELF AND ANY CHILDREN)***

Name______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$__________________ TANF
$ __________________ Veterans Benefits
$__________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only

Sub Total $__________

Name______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$__________________ TANF
$ __________________ Veterans Benefits
$__________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only

Sub Total $__________

Name ______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$__________________ TANF
$ __________________ Veterans Benefits
$__________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only

Sub Total $__________

Name______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$__________________ TANF
$ __________________ Veterans Benefits
$__________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only

Sub Total $__________

Name______________________________Age _____ Relationship____________________
Income: $__________________Wages/Salary Place of employment____________________
$ __________________ Interest/Dividends
$ __________________ Child Support
$ __________________ Social Security/SSI
$__________________ TANF
$ __________________ Veterans Benefits
$__________________ Pension
$ __________________ Unemployment
$ __________________ Other

Staff Use Only

Sub Total $__________

Total $ __________

Verified by: __________

All of the stated information is true and accurate. I understand that if I do not accurately report the total household income, my county of residence and my insurance status I will be responsible for any hospital services, physician services and medication costs at full market rate.

Signature: ______________________ Date: ______________

Family Health Centers
of Southern Indiana

Programs & Services/ Programas y Servicios

- Comprehensive Internal Medicine and Family Practice/ *Medicina Interna y Familiar Comprensiva*
- Acute Care---Colds, Flu, Strep throat/ *Cuidados Agudos—Resfriados, Gripe, infección de estreptococo*
- Immunizations/ Vacunas
- Preventative health screenings/ *Revisiones de Salud Preventivo*
- Office based gynecology procedures/ *Procedimientos Ginecológicos basados de oficina*
- Dental services/ *Servicios Dental*
- Case Management/ *Servicios de Gestión de Casos*
- Integrated Behavioral Health Services/ *Servicios de Salud Conductual*
- Pregnancy tests/ *Pruebas de Embarazo*
- Discounted prescription drug assistance programs/ *Programas de asistencia de medicinas recetadas en descuento*
- Maternal/Child Health Clinic (Clark and Floyd) / *Maternal/Clínica de Salud de Niño. (Condados de Clark y Floyd)*