"Healing with Heart"
Elica Health Centers

# PATIENT INTAKE FORM

Midtown Medical Center ☐ School Based Mobile ☐
West Sacramento ☐ WWW ☐
Arden Arcade ☐

## PATIENT INFORMATION

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

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

**Mailing Address:** _____ Apt. ____ City _____State ____ Zip_____

**Phone Number:** Home _____Cell/Alternate _____Work_____

**Best phone number for contact:** ☐ Home ☐ Cell ☐ Work ☐ Alternate

☐ Confidential/Speak Only to Me ☐ Do Not Call (If "Alternate" applies, whose phone number is this?)_____

**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

**Country of Origin**: _____ **Referred By:** _____

**Please state who the Head of the household is:**

First & Last Name:_____ Relationship to Patient: _____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: _____

**EMERGENY CONTACT:** (To be contacted **only** in the event of an emergency)

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, Elica Health Centers (EHC) is required by Federal Law to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is NOT reported or disclosed. The collection of this information also assists EHC 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

**How many people live in your home?** _____

**Patient Sexual Orientation:** ☐ 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

**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
☐ $5,500-$6,000 ☐ Over $6,000

Name: _____ DOB: _____

SOCIO-ECONOMIC INFORMATION (CONT.)

**Ethnicity: Hispanic or Latino?** ☐ Yes ☐ No ☐ Unreported/Refuse to Report

**Race: (**Mark all that apply) ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ African American/Black ☐ American Indian/Alaska Native ☐ European/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: _____

**I HAVE NO INSURANCE** ☐ ***Your household income and family size may qualify you and your family for Elica Health Centers' Sliding Fee Discount Program. Our Financial Advisor can assist you with any questions and how to apply.***

Assignment of Insurance Benefit: I hereby authorize payment directly to EHC of benefits otherwise payable to me but not to exceed EHC' regular charges for this service. I understand that I am financially responsible to EHC 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.

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 EHC' Collections Policy.

Elica Health Centers is not a free clinic and failure to fulfill your financial responsibility to us or agree to a payment schedule may result in your financial discharge from our services. In accordance with EHC' Collections Policy, EHC may choose to terminate its relationship with any patient who does not comply with this financial agreement.

I hereby acknowledge receipt of Elica Health Centers' Notice of Health Information Privacy Practices. I also agreeing to allow EHC 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.

**Initials:** _____ **Date**:_____

Name: _____ DOB: _____

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE and BILL OF RIGHTS and RESPONSIBILITIES**

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, EHC may require to share information when will 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 Elica Health Centers has given me a copy of the Privacy Notice, which explains how your health information will be handled in various situations.

☐ I have received Elica Health Centers Privacy Notice and Bill of Rights and Responsibilities.

☐ Elica Health Centers has given me the chance to discuss my concerns and questions about the privacy of my health information.

**Initials:** _____ **Date:**_____

**Elica Health Centers' staff should complete below if Acknowledgement & Rights and Responsibilities Form is not signed**

Does the patient have a copy of 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 to my understanding of the written or spoken information given during my health care visits.

**Consent for Treatment:** I request Elica Health Centers (EHC) to provide me 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 Elica Health Centers 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. In the event of any dispute between the patient, a dependent (whether or not a minor, the heirs—at—law, or the personal representative of the patient as the case may be, and the attending provider (including his/her agent or employee), involving a claim or tort or contractual agreement, if the dispute cannot be resolved on a voluntary basis, it is agreed that this dispute shall be submitted to a binding arbitration and not the court system. The rules, terms or procedures of said arbitration shall settle by mutual agreement of the parties if possible, pursuant to the arbitration rules then in effect.

**Right to Withdraw Consent:** I have the right to withdraw my consent for treatment of myself and/or my child 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.

**Initials:** _____ **Date:**_____

Name: _____ DOB: _____

## PATIENT COMMUNICATION CONSENT

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

It is in your best interest and in the best interest of Elica 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 EHC and medical staff to discuss my 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 chose to be "No Information," and I do not want any information released without my express consent.

| **Name:** | **Relationship to Patient:** | **Contact Info:** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| **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 Elica Health Centers 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 EHC 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 EHC to verify that information, and release it to referring/mutual providers of care.

**Patient or Legal Guardian Name: _____**

**Patient or Legal Guardian Signature: _____ Date: _____**

**Witness _____ Date: _____**