WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

DATE ____________ FIRST NAME ______________________ MIDDLE _______ LAST NAME __________________

DATE OF BIRTH ________________ MARITAL STATUS: ____________ PRIOR LAST NAME ________________

ADDRESS: ______________________________________ HOME PHONE: ________________

______________________________________ CELL PHONE: ________________

EMAIL: ____________________________________ ALTERNATE PHONE: ________________

CONTACT BY: Circle One: Home Phone Cell Phone Email SEX : M F SOCIAL SECURITY # ________________

PERSON TO NOTIFY IN CASE OF EMERGENCY ____________________________ TELEPHONE # ______________

FAMILY (PRIMARY CARE) PHYSICIAN: ____

HOW WERE YOU REFERRED TO OUR OFFICE: ____

IF MINOR CHILD – NAME OF PARENT OR GUARDIAN: ____

* GUARANTOR IS THE PERSON FINANCIALY RESPONSIBLE FOR BALANCES. IF OTHER THAN THE PATIENT PLEASE PROVIDE REQUIRED INFORMATION- GUARANTOR IS: PATIENT OTHER ________________

ADDRESS; ____ DATE OF BIRTH ______________

SOCIAL SECURITY # ____________________________ TELEPHONE # OF GUARANTOR: ______________

INSURANCE INFORMATION-PLEASE PROVIDE CARD

PATIENT WILL BE CONSIDERED A SELF-PAY ACCOUNT UNTIL INFORMATION IS PROVIDED

PRIMARY INSURANCE: ____

INSURANCE ADDRESS: ____

PRIMARY INSURANCE HOLDER INFORMATION: INSURED IS : PATIENT OTHER

INSURANCE ID# ____

GROUP ID# ________________________________

NAME OF INSURED (POLICY HOLDER): ____

POLICYHOLDER DATE OF BIRTH: ______________ RELATIONSHIP TO PATIENT ____________

ADDRESS OF INSURED: ____

TELEPHONE NUMBER OF INSURED: ____

SOCIAL SECURITY NUMBER OF INSURED: ____________________________________

SECONDARY INSURANCE: ____

INSURANCE ADDRESS ____

SECONDARY INSURANCE HOLDER INFORMATION: INSURED IS: PATIENT OTHER

INSURANCE ID# ____

GROUP ID# ________________________________

NAME OF INSURED (POLICY HOLDER) : ____

POLICYHOLDER DATE OF BIRTH: ______________ RELATIONSHIP TO PATIENT ____________

ADDRESS OF INSURED: ____

TELEPHONE NUMBER OF INSURED: ____

SOCIAL SECURITY NUMBER OF INSURED: ____________________________________

PHARMACY PREFERENCE ____________________ CITY/STATE ______________________________

I undersigned, hereby CONSENT TO TREATMENT and grant permission to release my medical information and to authorize payment of health insurance benefits to the above-named doctor(s). I also understand that I am fully responsible for payment of deductibles and co-insurance and any charges that are incurred and not covered by my health insurance.

Signature: ____ Date: ______________________

PAYMENT: We accept cash, checks and credit cards. Payment is due upon receipt of medical services. Co-payments must be paid at the time of your visit. If financial arrangements are needed, please notify the receptionist, as approval will be needed before your visit.

Wayne Memorial Community Health Centers

A Wayne Memorial Health System Affiliate

PATIENT RECORD OF DISCLOSURES

In general, *the* HIPAA PRIVACY RULE permits WMCHC to communicate with our patients regarding their health care. This includes communicating with our patients at their homes, whether through the mail or by phone or in some other manner. In addition, the Rule does not prohibit WMCHC from leaving messages for patients on their answering machines. Please select your preferences below. WMCHC recognizes our patients' right to request a restriction on uses and disclosures of their protected health information (PHI). Patients can request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Please note any preferences below.

In an effort to protect our patients' privacy, generally we will not disclose protected health information to anyone other than the patient if over the age of 18, unless express permission is granted to another person through the patient permission section on this form below.

PATIENT NAME: ______________________________ **Date of Birth:** ____________

☐ **Home Telephone** ____________________
- ☐ OK to leave a message with detailed information
- ☐ Leave a message with a call back number only

☐ **Cell Phone** ____________________
- ☐ OK to leave a message with detailed information
- ☐ Leave a message with a call back number only

☐ **Work Telephone** ____________________
- ☐ OK to leave a message with detailed information
- ☐ Leave a message with a call back number only

☐ **Written Communication**
- ☐ OK to mail to my home address
- ☐ OK to send email to my email address

☐ *Other* ____________________

Please indicate the BEST WAY TO REACH you:

____

CELL/HOME/WORK PHONE # or EMAIL

(Write in please and circle one)

PLEASE PROVIDE YOUR EMAIL ADDRESS:

____

EMAIL ADDRESS

Alternate Contact: *Person to whom we may disclose your health information:* ☐ check box if **NONE**

Print Person/Alternate Contact's Name:____________________ Relationship: ____________
Best number to reach this person: ______________________________

Print Person/Alternate Contact's Name:____________________ Relationship: ____________
Best number to reach this person: ______________________________

Print Person/Alternate Contact's Name:____________________ Relationship: ____________
Best number to reach this person: ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I acknowledge that I have received the Notice of Privacy Practices for Wayne Memorial Community Health Centers. I have been given an opportunity to ask any questions regarding the privacy notice that I may have at this time, and agree to have my health information disclosed (as necessary) as indicated above. I am also aware that I may contact the privacy officer at 570-251-6676 if I have any further questions.

Patient Signature: ______________________________ Date ____________

Parent/Guardians Signature: ______________________________ Date ____________

PRINT NAME: ______________________________

Voluntary Confidential Information

Why are we asking for this information? WMCHC develops and expands services in our community utilizing federal grant funds. Collection of the information below allows us to access grant funds bringing more health care services and health care jobs to our area. Your help in obtaining this information is greatly appreciated. **These statistics are reported to the government in total not by individual name.** We would like you to fill out the form completely but understand if there are questions you do not want to answer. **Thank You.**

1) **What is your primary language?**
☐ English ☐ Deaf/Sign Language
☐ Non-English ☐ Interpreter Required

2) **Sex at Birth:**
☐ Male
☐ Female

3) **Sexual Orientation:** ☐ **Choose not to disclose**
☐ Straight or heterosexual
☐ Lesbian /Gay
☐ Bisexual
☐ Something Else
☐ Don't know

4) **Gender Identity:** ☐ **Choose not to disclose**
☐ Male
☐ Female
☐ Transgender Male/ Female-to-Male
☐ Transgender Female/ Male-to-Female
☐ Other

5) **Ethnicity:** ☐ **Choose not to disclose**
Hispanic or Latino ☐ Yes ☐ No

6) **Race:** ☐ **Choose not to disclose**
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black/African American
☐ American Indian/Alaskan Native
☐ White/Caucasian
☐ More than one race

7) **Insurance:**
☐ Chip
☐ Medicaid (Access includes Access HMO)
☐ Medicare (including Medicare replacement)
☐ Dual Eligible (Medicare/Medicaid)
☐ Self Pay
☐ Commercial (Aetna, Highmark, GHP, Unions)
☐ Other________________________________

8) **Income Range:** **(Total Family Income)** ☐ **Choose not to disclose**

Family Size: _______ (Number of dependents, including yourself and spouse)

If you do not wish to report your family income, please mark ☐ **(Choose not to disclose)**. Thank you.

☐ $0-$10,999
☐ $11,000-20,999
☐ $21,000-$30, 999
☐ $31,000-$40, 999
☐ $41,000-$50, 999
☐ $51,000-$60, 999
☐ $61,000-$70, 999
☐ $71,000-$80, 999
☐ $81,000-$90, 999
☐ $91,000-$100, 999
☐ $101,000 and above

Are you a dependent? ☐ Yes ☐ No

9) **Please check any of the following that apply:**
Are you a veteran of the armed services? ☐ Yes ☐ No
Migrant Agricultural Worker ☐ Yes ☐ No
Seasonal Agricultural Worker ☐ Yes ☐ No

10) **Homeless** ☐ Yes ☐ No (Definition of a homeless person- person who lack housing. This includes persons living with friends & relatives- doubling up.)
Please define type of Homeless
☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street

Reduced Fees:
☐ Yes, I would like to be contacted about the sliding fee program.
☐ No, I would not like to be contacted about the sliding fee program.

WAYNE MEMORIAL COMMUNITY HEALTH CENTERS
A Clinical Affiliate of Wayne Memorial Health System, Inc.

Patient Name: ______________________________ Date of Birth: _________________

Acknowledgment of Receipt of Patient-Centered Medical Home Information (PCMH)

Wayne Memorial Community Health Centers, a Federally Qualified Health Center (FQHC) and a clinical affiliate of Wayne Memorial Health System, is a Patient Center Medical Home recognized through National Committee for Quality Assurance for its primary care practices.

My signature below constitutes my acknowledgment that I have been provided with a copy of a description, the responsibilities and standards required to achieve and maintain designation as a PCMH.

I understand it is my responsibility to provide a complete medical history and information about care obtained outside the practice upon receiving care through Wayne Memorial Community Health Centers.

_____________________________________ _________________________
Signature of Patient or Legal Representative Date

If signed by legal representative; relationship to patient: ______________________________