Estella Byrd Whitman Community Health Center Health Care Application

MUST BE UPDATED ANNUALLY

PATIENT INFORMATION

Last Name	First Name	MI	DOB (MM/DD/YY)	SS#

Street Address	City	State	Zip	County

Is Patient Insured?

Medical ☐ Yes ☐ No

Dental ☐ Yes ☐ No

If Patient under 18:

Mother's Name **Father's Name**

CONTACT INFORMATION

Primary Phone Number		Secondary Phone Number	
	☐ Home ☐ Cell ☐ Work		☐ Home ☐ Cell ☐ Work

EBWW staff may contact me for clinical/appointment reminders by the following methods: (check all that apply)

☐ **Text message** (Standard data/messaging rates may apply) ☐**Email:** _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

PATIENT DEMOGRAPHICS

Primary Language Spoken

☐ English ☐ Spanish ☐ Other:_____

Would you like an interpreter?

☐ Yes ☐ No

Race (Check all that apply)

☐ Asian ☐ Black ☐ White ☐ Central American Indian

☐ American Indian/Native Alaskan ☐ Pacific Islander

☐ Native Hawaiian ☐ Other: _____

Ethnicity

☐ Hispanic/Latino

☐ Non-Hispanic/Latino

Gender Identity:

Do you think of yourself as:

☐ Male

☐ Female

☐ Transgender (☐ Male-to-Female ☐ Female-to-Male)

☐ Other, please specify:

☐ Prefer not to disclose

Sexual Orientation:

What do you think of yourself as?

☐ Straight or heterosexual

☐ Lesbian, gay, or homosexual

☐ Bisexual

☐ Something else ☐ Don't Know

☐ Prefer not to disclose

Marital Status

☐ Single

☐ Married

☐ Divorced

☐ Widowed

Student

☐ Full-Time

☐ Part-Time

☐ Not a student

Employment Status

☐ Full-Time

☐ Part Time

☐ Un-Employed

☐ Retired

Employer	Zip Code	Migratory or Seasonal Agricultural Worker?	Military Veteran?
		☐ Yes ☐ No	☐ Yes ☐ No

How Did You Hear About the Health Center? Circle One

Family Friend Flyer Hospital Local Health Fair Internet Other: _____

PREFERRED PHARMACY: _____ **(include address)**

Would you like to learn more about our **sliding fee scale program** and a possible discount on your bill? ☐ **Yes, Interested**

Gross Household Income (Before Taxes):

$_____ ☐ Monthly ☐ Annually

 # Adults & Children in Household: _____

☐ **Prefer not to disclose income.**

Services not covered by your 3rd party insurance may be eligible for a discount depending on your income level. If you do not wish to disclose your income, you will be responsible for any balance not paid by 3rd party insurance.

INSURANCE

Primary Medical Insurance: _____

Subscriber Number: _____

Policy Holders Name: _____ Self Parent Spouse

Secondary Medical Insurance: _____

Subscriber Number: _____

Policy Holders Name: _____ Self Parent Spouse

Patient/Parent/Legal Guardian Signature: _____ Date: _____

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All patients are requested to read, initial, and comply with Estella Byrd Whitman's policies below. If you have any questions about our policies, please ask to speak with our Office Manager.

Notice of Patient Privacy Practices

I understand that as a patient of Estella Byrd Whitman Community Health Center, all information collected will be kept confidential under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I acknowledge that I have received the Notice of Privacy Practices from Estella Byrd Whitman Community Health Center.

Initial Here: _____

Appointment Expectations:

Please arrive 30 minutes prior to your appointment to register. All payments are expected at the time of service. Alert a staff member of any changes in your information to make sure we have the most updated information in your account. Make sure you provide proper identification, required documentation, and insurance cards (if any) at the time of the visit. **Minors must always be accompanied by an adult.**

Initial Here: _____

Appointment Confirmation

Your appointment must be confirmed 24 hours before the scheduled appointment, if the health center cannot confirm your appointment, your appointment may be cancelled. We will do everything possible to reschedule your appointment depending on the availability of your provider.

Initial Here: _____

Late Arrival

Patients that **arrive** at the front desk **more than 15 minutes after their scheduled appointment** may not be seen. We will do everything possible to reschedule your appointment depending on the availability of your provider.

Initial Here: _____

Cancellation Policy

Patients that need to cancel or reschedule an appointment may do so by calling Estella Byrd Whitman's main office number 352-875-2226.

Appointment cancellation requires 24-hour advanced notice. Voicemail messages left 24 hours in advance will suffice as notification to EBWW. Failure to cancel an appointment will result in a **"no-show"** entry in your record. **Once three** (3) **no-shows are recorded in your record, it will be required that all future appointments are by walk-in only.** Sick patients will be seen on a first come, first served walk-in basis daily.

Initial Here: _____

PATIENT CONSENT FOR TREATMENT

By signing below, I, (or my authorized representative on my behalf) authorize Estella Byrd Whitman providers and their staff to conduct any diagnostic examinations, tests and procedures, as well as provide any medications, treatment or therapy necessary to effectively assess and maintain my health, to assess, diagnose and treat my illness or injuries. I understand that, excluding emergencies or extraordinary circumstances, it is the responsibility of my individual treating health care providers to explain to me the reasons for any diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT: In giving my general consent to treatment, I understand that I retain the right to refuse any examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Signature:

_____

Patient/Parent/Legal Guardian Signature **Date**

HIV, HEPATITIS B & C TESTING

If Estella Byrd Whitman staff comes in contact with my or my children's body fluids, I consent to be tested for HIV, Hepatitis B and C.

_____

Patient/Parent/Legal Guardian Signature **Date**

PERSONS AUTHORIZED TO OBTAIN MEDICAL INFORMATION

I agree that Estella Byrd Whitman Community Health Center may disclose certain parts of my health information to a Personal Representative of my choosing, since such a person is involved with my health care or payment relating to my health care. In that case, Estella Byrd Whitman staff will disclose only information that is directly relevant to the person's involvement with my health care (including medical documentation and appointments) or payment relating to my health care.

Note: If the patient is a child under the age of 18, parents do not need to be listed.
If patient would like their spouse or partner to have access, the spouse or partner needs to be listed below.

Name	Relationship	Phone	DOB
Name	**Relationship**	**Phone**	**DOB**

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FINANCIAL RESPONSIBILITY AGREEMENT

Payment is expected at the time of service. Payment may be made by cash or major credit card. Any fees, deductibles, co-insurance, or co-payment are payable at the time of service.

PAYMENT RESPONSIBILITY:
The undersigned assumes responsibility for payment for services in accordance with the standard rates and terms of Estella Byrd Whitman Community Health Center (EBWW) whether to sign as a patient or guarantor, **whether insured or uninsured**. As the undersigned, I fully understand: (a) my insurance, if any, is a contract between myself and the insurance company, except in certain cases where **EBWW** has a specific contract with my PPO, HMO, or other third-party payer; **EBWW** does not explain nor determine if services are covered by my insurance. Any inquiries to explain or determine insurance coverage for services are between myself and the insurance company; (b) any balance remaining after insurance approves or denies payment is my responsibility to pay; if my insurance company denies a claim for services for any reason, whether at the time or subsequent to receiving services, I assume full responsibility for payment in accordance with the standard rates and terms of **EBWW**; (c) if I am not able to pay the standard rates for services received or to be rendered, whether insured or uninsured, I can apply for **EBWW's** Sliding Fee Discount Program.

In the event all charges for services are not paid in full when due, whether insured or uninsured, and collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for balance of charges for services and treatment received and all costs reasonably associated with such collection activity including, but not limited to, reasonable collection fees, attorney's fees, and court costs.

I hereby authorize **EBWW** to release all medical information to all my insurance carriers, other third-party payers, including Medicare or its agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Worker's Compensation or other insurance purposes. Please note, if your primary care provider (PCP) is not updated at the time of your visit, you will be responsible for any fees associated with the office visit.

PHARMACY BENEFIT MANAGEMENT:
The undersigned authorizes EBWW to obtain pharmacy and prescription information needed for accuracy and continuity of care.

AUTHORIZATION TO PAY INSURANCE BENEFITS:
I hereby authorize the payment of any insurance or other medical benefits directly to Estella Byrd Whitman Community Health Center. The undersigned, having read and understood the agreement, accepts this financial responsibility agreement.

Signature: _____
Patient/Parent/Legal Guardian Signature Date

Witness Signature: _____
Date