HealthReach Community Health Centers - 2024

PATIENT INFORMATION			
Last Name:	First:	MI:	Nickname:
Date of Birth: / /	Social Security Number:	According to your insurance coverage, what is your sex: ❑ M ❑ F	
Mailing Address:		Physical/Local Address: ❑ Same as mailing address	
		Street:	
City:	State:	City:	State:
Zip Code + 4		Zip Code + 4	
Home Phone:	Day Phone:	Other Phone:	
Primary Care Provider:			
Dental Provider:			
Please share your email address. You may opt out of receiving electronic information from us at any time.			
Email Address:			

INSURANCE INFORMATION	
Please have the receptionist scan your insurance card/cards. **If your <u>insurance card is not current</u> or available, you may be billed.**	
Primary Insurance Name:	**Primary Insurance Policy #:**
Name of Policy Holder (if different than patient):	
Secondary Insurance Name:	**Secondary Insurance Policy #:**
Name of Policy Holder (if different than patient):	

PAYMENT OF BENEFITS: I authorize my health insurance carrier(s) or other third-party payers responsible for payment for my health care, including Medicare, MaineCare and other governmental and commercial insurers, to pay the costs associated with health care services rendered to me by HealthReach Community Health Centers ("HRCHC"). I hereby assign to HRCHC any rights I might have to receive payment directly from such insurance carriers and third-party payers and authorize my insurance carriers and third party payers to pay HRCHC directly for the health care services provided to me. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance (including copays, coinsurance, and deductibles) on my account for any health care services rendered by HRCHC. I understand that health information about me may be shared with my health insurance carrier(s) or other third-party payers responsible for paying for my health care.

GUARANTOR INFORMATION – Person Responsible for Payment ❑ Self, if not self-fill in spaces below			
Last Name:	First Name:		Middle Initial:
Date of Birth: / /	Relationship to Patient: ❑ Spouse ❑ Parent ❑ Other		
Mailing Address: (If different than patient)	City:	State:	Zip:
Home Phone Number:	Day/Work Phone Number:		

EMERGENCY CONTACT INFORMATION ❑ None ❑ Guarantor ❑ if other fill in space below.	
Name:	Relationship:
Home Phone Number:	Day/Work Phone Number:

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Name of Patient: _____ Date of Birth: _____

OTHER REQUIRED INFORMATION

This site is a Federally Qualified Health Center (FQHC) which means we receive a federal grant that allows us to provide a discounted fee program to our patients who qualify. We are required to provide certain information to the Bureau of Primary Health Care each year regarding all of our patients. Please check off all boxes that apply to you (or the patient that is being seen).

Race (check all that apply)		**Ethnicity (check one)**
☐ American Indian, Native Alaskan	☐ Japanese	☐ Chicano
☐ Asian	☐ Korean	☐ Cuban
☐ Asian Indian	☐ More than one race	☐ Declined to Specify
☐ Black or African American	☐ Native Hawaiian	☐ Hispanic or Latino
☐ Chinese	☐ Other	☐ Mexican
☐ Declined to specify	☐ Other Pacific Islander	☐ Mexican American
☐ Filipino	☐ Other Pacific Islander (Not Hawaiian)	☐ Not Hispanic or Latino
☐ Guamanian or Chamorro	☐ Samoan	☐ Puerto Rican
☐ Hawaiian	☐ Vietnamese	
☐ Hispanic	☐ White	

Preferred Language?		**Do you need? (if applicable, check)**
☐ English	☐ Spanish	☐ An Interpreter
☐ French	☐ Other (please specify)_____	☐ Sign Language
Are you currently without housing (homeless)?		**Check one (if applicable)**
☐ Yes		☐ Migrant Agricultural Worker (moves from place to place for work)
☐ No		☐ Seasonal Agricultural Worker (does not move for work)
☐ Unknown/unreported		

Have you ever served in the U.S. Military? (Air Force,Army, Coast Guard, Marines, National Guard, Navy etc.)

☐ Yes
☐ No

Sexual Orientation – Do you think of yourself as…?	**Gender Identity – What is your current gender identity? (check all that apply)**
☐ Lesbian, gay, or homosexual	☐ Female
☐ Straight or heterosexual	☐ Male
☐ Bisexual	☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Something else	☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Don't know	☐ Additional Gender Category (or Other), please specify: _____
☐ Declined to answer	☐ Declined to answer

What sex were you assigned at birth on your original birth certificate? (check one)

☐ Male
☐ Female
☐ Declined to answer

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Name of Patient: _____ Date of Birth: _____

Circle the category below that best describes your income level as it relates to your family size (circle the LETTER).							
◯ Category A		◯ Category B		◯ Category C		◯ Category D	
Family Size	**Yearly Income Up to:**	**Family Size**	**Yearly Income Up to:**	**Family Size**	**Yearly Income Up to:**	**Family Size**	**Yearly Income Up to or ABOVE:**
1	$15,060	1	$22,590	1	$30,120	1	$30,121
2	$20,440	2	$30,660	2	$40,880	2	$40,881
3	$25,820	3	$38,730	3	$51,640	3	$51,641
4	$31,200	4	$46,800	4	$62,400	4	$62,401
5	$36,580	5	$54,870	5	$73,160	5	$73,161
6	$41,960	6	$62,940	6	$83,920	6	$83,921
7	$47,340	7	$71,010	7	$94,680	7	$94,681
8	$52,720	8	$79,080	8	$105,440	8	$105,441
For each additional person, add $5,380 yearly							

CONSENT FOR TREATMENT AT THE HEALTH CENTER:

1. I am aware that the practice of medicine is not an exact science and that HRCHC offers no guarantees concerning any treatments or examinations I may have here.
2. I understand that HRCHC and its employees may use the information contained in my record for proper medical purposes, and for clinical improvement audits.
3. I authorize the medical staff of HRCHC to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
4. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

NOTICE OF PRIVACY PRACTICES: By initialing here, I acknowledge that I have received a copy of HealthReach Community Health Centers' Notice of Privacy Practices.

Patient/Authorized Representative* Initials in box (right) : ☐

[Staff: If initials are not provided, document reason.]

SIGNATURE: By signing below, I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

_____ _____

Signature of Patient or Authorized Representative* Date

**If signed by an Authorized Representative:*

_____ _____

Printed Name of Authorized Representative Source of Authority (e.g., guardian, power of attorney)