

Fordland Clinic: Adult Patient Information and Consent Form

Name: Last: _____ First: _____ MI: _____

Mailing Address _____ City _____ State _____ Zip _____

County _____ Phone # _____ Cell # _____ Alt # _____

Date of Birth ____/____/____ Age ____ Sex M / F Marital Status: S M D W

Gender Identity: Male Female Transgender Other

Sexual Orientation: Straight Gay/Lesbian Bisexual Other

Soc Sec# ____ - ____ - ____ E-Mail Address _____

Spouse Name: _____ Contact # _____

I **do not** want to be contacted by email for: General health information including the quarterly newsletter
 Specific medical info about my health condition(s) Direct contact with my provider Fundraising

Please indicate if you are: Homeless Migrant Farm worker

Are you a Veteran Yes No

Race: White Black/African American Asian American Indian/Alaskan Native Native Hawaiian
 Other Pacific Islander Unknown

Are you of Hispanic/Latino origin? Yes No

Are you disabled? Yes No Current Student? No Full Time Part Time

Education Level: Less than High School HS Diploma Some College/Vocational College Grad

Highest grade of school completed (circle one) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Is your primary language English? Yes No If no, please specify _____

Emergency Contact Person: _____ Phone: _____

Family Size _____ Annual Family Income (please circle) Less than \$10,000
\$10,001 to \$25,000
\$25,001 to \$40,000
\$40,001 to \$55,000
\$55,001 to \$70,000
Greater than \$70,000

How did you hear about our clinic?

friend/family newspaper (please list) _____ website
 yellow pages sign in front of clinic billboard east (coming from Rogersville)
 billboard west (coming from Seymour) other _____

Why are we asking for so much information? Fordland Clinic is a not-for-profit community health center, and as a non-profit, we can apply for grants to expand services. Many grant organizations request we provide demographic information about the patients we serve. Your privacy is important to us, we do not share your personal information or identity with third parties or advertising agents.

RESPONSIBLE PARTY/EMPLOYER INFORMATION/INSURANCE CARRIER

(Please give all insurance cards to the receptionist)

Person responsible for bill: _____ Date of birth: ____/____/____

Address (if different from above): _____ Phone: _____

Employer: _____ Employer Phone: _____

Method of Payment: Insurance _____ Cash _____ Credit Card _____

Primary Medical Insurance:

Medicare Medicaid BCBS UHC Mercy Cox Other: _____

Secondary Medical Insurance:

Medicare Medicaid BCBS UHC Mercy Cox Other: _____

Dental Insurance Company: _____ **Policy#** _____ **Group#** _____

Patient's relationship to Insured: Self Spouse Child Step Child Other: _____

Consent for Treatment: This is to certify that I, the undersigned, consent to the administration of whatever anesthetics and the performance of whatever medical and/or dental procedures may be decided on by myself and the attending provider to be necessary or advisable, rendered via face-to-face interaction or telemedicine. I, hereby voluntarily request, consent to, and authorize Fordland Clinic dentists, hygienists, physicians, Nurse Practitioners, behavioral health clinicians or other practitioners to provide medical and surgical treatment, including but not limited to, diagnostic procedures, lab testing, and administration of medications, as is deemed necessary and advisable. I further understand and acknowledge that HIV and Hepatitis testing may be performed upon my child, or me without written consent, under the circumstances that a Fordland Clinic employee sustains a percutaneous mucous membrane or other exposure to my blood or other bodily fluids.

Information: I certify the information that I have given in this form is correct. Should there be any changes, I will notify the provider prior to treatment.

Assignment of Insurance benefits: I request payment of authorized Medicare &/or other Insurance benefits on my behalf for any services furnished to me by Fordland Clinic, Inc. I agree to pay any collection fees in the event that my account is turned over to a collection agency for failure to pay outstanding charges for more than 3 months. I understand that I may be responsible for additional charges generated from abnormal lab or pathology results.

Release of Information: I also authorize Fordland Clinic, Inc. to release the minimum necessary medical and/or billing information concerning my care, including copies of my medical records, electronically or on paper, for the purpose of ongoing medical treatment and billing for services provided. I acknowledge that this authorization is valid for one year, or until all accounts are settled.

Photo Release: I give Fordland Clinic (FC) the right to use my name, photograph, image or voice in all forms for promotion of FC or media coverage of FC and its events with no monetary compensation to myself.

HIPPA: I acknowledge that I have been notified of FC's HIPAA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices. I have been given a chance to review them and offered a copy. I also acknowledge that if I wish to have a copy, in the future, it is available to me. I understand that general e-mail is not a secure method of communication, and if I send e-mail to a provider or request a provider respond to me by e-mail I acknowledge that I am aware that this is not secure, and is not compliant with HIPA rules & regulations.

Patient/Parent/Guardian Signature Date Witness Date

Name of family health care provider: _____

Name of family dental provider: _____