HealthReach Community Health Centers

PATIENT INFORMATION

Last Name:	First:	MI:	Nickname:
Date of Birth: / /	Social Security #:	According to Insurance (Sex): ☐ M ☐ F	

Mailing Address:		Physical Address: ☐ Same as Mailing Address	
Street/PO Box:		Street:	
City:	State:	City:	State:
Zip Code +4:		Zip Code +4:	
Primary Phone: ☐ Cell ☐ Home ☐ Other		Secondary Phone: ☐ Cell ☐ Home ☐ Other	
Primary Care Clinician:		Dental Clinician:	

Email Address:

You may opt out of receiving email communication from us at any time

INSURANCE INFORMATION

The receptionist will scan your insurance card(s). If your insurance card is not currently available, you risk getting 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, Maine Care 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 of Services

☐ If Self, Check Here – If not Self, Fill in all information below

Last Name:	First:	MI:	
Date of Birth: / /	Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other		
Mailing Address: (if different than patient)	City:	State:	Zip:
Primary Phone #1:	Secondary Phone #2:		

EMERGENCY CONTACT INFORMATION

☐ None ☐ Guarantor If Other, provide the requested information below

Name:	Relationship:
Primary Phone #1:	Secondary Phone #2:

Name of Patient:	Date of Birth: / /

RACE (Check all that apply)				ETHNICITY (Choose one)	
	American Indian, or Alaska Native		More than one race		Chicano
	Asian		Native Hawaiian		Cuban
	Asian Indian		Other		Declined to Specify
	Black or African American		Other Pacific Islander		Hispanic or Latino
	Chinese		Other Pacific Islander (Not Hawaiian		Mexican
	Filipino		Samoan		Mexican American
	Guamanian or Chamorro		Vietnamese		Not Hispanic or Latino
	Hawaiian		White		Puerto Rican
	Japanese		Declined to Specify	**CURRENTLY IN THE MILITARY OR A VETERAN?**	
	Korean				Yes / No

PREFERRED LANGUAGE				ARE YOU IN NEED OF? (IF APPLICABLE)	
	English		Spanish		An Interpreter
	French		Other:		Sign Language

ARE YOU CURRENTLY WITHOUT HOUSING?				AGRICULTURAL WORKER (IF APPLICALBE)	
	Yes		No		Migrant Agricultural Worker (moves from place to place)
	Unknown/Unreported				Seasonal Agricultural Worker (does not move for work)

SEXUAL ORIENTATION				GENDER IDENTITY			
	Lesbian, Gay, Homosexual		Straight, Heterosexual		Female		Other:
	Bisexual		Something Else		Male		Declined to Answer
	Don't Know		Declined to Answer		Female-to-Male/Transgender Male/Trans Man		Male-to-Female/Transgender Female/Trans Woman

PREFERRED PRONOUNS		SEX ASSIGNED AT BIRTH	
	He/Him/His		Male
	She/Her/Hers		Female
	They/Them/Theirs		Declined to Answer

ANNUAL INCOME	
Family Size:	Annual Household Income:
Head of Household:	

What is a household?

Households refer to all people related by birth, marriage, or adoption who reside together, dependents, and others in the same tax household. Individuals who are 19 or older and not dependents living at the same address is considered separate households. The following comprises the household:

- The applicant
- Spouse
- Domestic Partner when the applicant provides greater than 50% of the financial support (necessary living expenses) of the domestic partner.

Domestic Partnerships are defined as two individuals who are unmarried, 19 years or older, and who reside together.

- Anyone under 19 years of age who lives with and is supported by the applicant.
- Anyone claimed as a dependent on the applicant's federal tax return.
- Anyone who claims the applicant on a federal tax return or is their tax dependent. If applicant is claimed as a dependent on a federal tax return, then the person(s) who claimed the applicant is considered part of the household and income verification is required.

Name of Patient:	Date of Birth: / /

CONSENT FOR TREATMENT IN OFFICE AND TELEHEALTH

1. I consent for HRCHC, and its providers and other staff, to provide telehealth services to me. Use of telehealth services is voluntary. Refusing telehealth services will not affect my right to future care and treatment. Telehealth services involve medical evaluation, diagnosis, and treatment using interactive audio, video, and data communication with my provider, who is at a different location than me. Telehealth appointments will not be audio or videotaped without my consent. I understand that the alternative to a telehealth visit is an in-person visit with a provider.
2. If I am a Maine Care member: (1) refusing telehealth services will not risk loss or withdrawal of my Maine Care benefits; and (2) Maine Care will pay for my transportation to receive Maine Care covered services as allowed under Maine Care rules.
3. Some services are not available through telehealth, such as services that require an in-person physical exam. Telehealth may not be appropriate for every medical condition. I may need to follow up with a health care provider in-person or receive diagnostic tests. My provider will tell me if further evaluation is needed. Certain medicines may not be prescribed for a telehealth visit. If I am experiencing a medical emergency, I will not try to contact my provider by telehealth. I understand that I should go to the nearest emergency room or dial 9-1-1 or another local emergency number.
4. I have the right to be informed of who will be present with my provider rendering telehealth services to me and at the site where I am receiving services. I have the right to exclude anyone from either site. I will be provided with contact information for the provider(s) and staff who will see me on each telehealth visit.
5. I will physically be in the State of Maine for each telehealth visit. HRCHC providers are licensed in Maine and there are restrictions on providing telehealth services to patients outside of Maine. If I am not in Maine, my provider may not legally be able to provide services to me. I will be asked to confirm my identity and location for each telehealth visit.
6. There are inherent risks in the use of telehealth. It is possible that transmission of data and equipment may fail or be disrupted or distorted. HRCHC takes reasonable steps to ensure its telehealth service is secure and complies with applicable privacy and security laws. However, it is impossible to fully guarantee against security or privacy risks. In addition, telehealth may not be as effective or complete as an in-person visit.
7. I will have access to all information resulting from telehealth services as provided by law. HRCHC may use and disclose this information as allowed by law. As part of the technologies used in providing telehealth services, information may be collected and passive tracking mechanisms may be used by these technologies. This information may include, without limitation, performance data and information related to my connection used in the visit, such as my name, IP address, location, and other details about the visit.
8. If I have a complaint about HRCHC's telehealth services, I may ask HRCHC how to make a complaint.
9. I am aware that the practice of medicine is not exactly scientific and that HRCHC offers no guarantees concerning any treatments or examinations I may have here.
10. I understand that HRCHC and its employees may use the information contained in my record for proper medical purposes, and for clinical improvement audits.
11. 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.
12. 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 it 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)