Thank you for choosing Health West for your healthcare needs. Health West strives to provide quality and affordable healthcare for everyone. Please answer the following questions to help us serve you better.

Clinic Location________________________________

1. How did you hear about Health West? (If a friend, whom may we thank?)

   ____

2. Which of the following do you use?

   Internet Email TV Phone Radio Newspaper (name___________________)

3. Where do you get your health information from? (please circle all that apply)

   Friends Family Internet Books Health Fairs Healthcare Facility T.V.

   Other _________________

4. Have you heard about Health West from any of the following? (please circle all that apply)

   Friends Family Internet Radio Newspaper Health Fairs Healthcare Facility

   T.V. ValPak Direct Mail Other _________________

Patient Demographic Information

Patient Information Date: ____________________

Name ________________________________ **Date of Birth**: ____________ Social Security #_____-______-_____

Address ____________________________________ P.O. Box____________ Marital Status: S M W D SEP

City ______________________________ **State**_________ **Zip Code**________________ Sex: M F

Do You Consider Yourself Hispanic/Latino? Y N Race:____________________ Preferred Language: ______________

Place of Birth: ____ Home Phone: __________________

Cell Phone: ___________________ Carrier: ___________________ Message Phone: _____________________

Email Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Preferred Method of Communication: Home Phone _____ Cell Phone _____ E-Mail_____ Regular Mail_____ Other_________

Name of Spouse: ____ Phone Number: ____________________

Are you a student: Y or N FT / PT Veteran: Y or N Do you have a Living Will or an Advance Directive? Yes No

Emergency Contact: Name____________________________________Phone #________________________

Relationship to Patient: _____________________________________ Do you need a translator? Yes No

Primary Care Provider (If you have one): __________________________ Primary Pharmacy___________________

Information of Person Responsible for Payment (If different from patient)

Name_________________________________ **Date of Birth**____________ Social Security # _____-_____-_____

Address ____ Relationship to Patient_____________________

Home Phone_________________ Work phone______________________ Cell phone______________________

Primary Insurance Carrier ___________________ **Policy Holder** ______________________ **Date of Birth** ___________

Secondary Insurance Carrier ___________________ **Policy Holder**______________________ **Date of Birth**___________

Employer Name & Address____________________________________Occupation_________________________

List Names of Family Members living in same household ____

Within the last 2 years, have you worked on a farm or in the field, doing such things as hoeing beets, cutting potato seeds, working the harvest, moving pipe or other farm labor? Yes No

If yes, how many months did you work? _________________

If yes, was that work the main source of income for you? Yes No

In the past 2 years, did you ever move to do farm labor? Yes No

Have you ever done seasonal farm work or moved to do farm work? Yes No

***Bold** Type indicates a required field

Patient-Centered Medical Home (PCMH) is a home for all your health care needs and has a team of people in place to provide you with the resources to make sure you get the care you need. PCMH practices use a team-based approach, led by your doctor, to make it easier for you to access the care, information and assistance you need, when you need it. The PCMH model also promotes wellness exams and preventive care to keep you healthy. Using your PCMH as your first point of contact allows you to receive more coordinated, personalized health care. Your PCMH has a care coordinator dedicated to providing you with information and additional resources to take care of your health. As part of your PCMH we also care about your privacy. Please read the notice on privacy practices and sign below.

Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgment of Receipt

I, ______________________________, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

____

Patient's Signature **Date**

____

Signature of Parent or Patient's Representative (if applicable) **Date**

____

Description of Legal Authority to Act on Behalf of Patient

Financial Consent Form

Please understand that your treatment is conditioned on payment of your bill. We require payment at the time of service. However, we offer sliding fee discount to patients who are eligible. *If your income is low, you may qualify for a reduced charge. If you feel you might qualify, ask us for an application form.*

Please read, agree to, and sign the following financial agreement prior to any treatment.

Authorization of Treatment

I hereby authorize Health West and its affiliated providers and staff to examine, test, and treat me or my dependent(s) for any medical and/or behavioral health condition. I understand that no guarantees have been made to me regarding treatment or examination. In case of an emergency, in which I cannot be reached, I authorize Health West to treat my dependent(s).

__________ Initial

Assignment and Authorization

I hereby assign and authorize direct payment to Health West of any payments or other benefits to which me or my dependent(s) may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with our care. I agree that this assignment will not be withdrawn or voided at any time until Patient's account is paid in full. To the extent such authorization is required by applicable regulations, I hereby authorize Health West or any other holder of medical information about the Patient to release such information to the Centers for Medicare and Medicaid Services and its agents as necessary to determine benefits payable for services provided to Patient. This authorization shall not modify or limit Practice's right to use or disclose protected health information as otherwise allowed by applicable law or Practice's Notice of Privacy Practices. **<u>I understand that I am responsible for any amount not covered by insurance.</u>**

__________ Initial

Authorization for Electronic Communications

To provide the best care possible, Health West seeks to communicate with its patients in a convenient and effective manner, including e-mail, text, patient portal messaging or other electronic means if requested by the patient and deemed appropriate by Health West. Please note that Health West makes every effort to keep your information confidential. However, such communications sent through the internet or over phone systems may not be encrypted or secure, and could result in unauthorized persons retrieving your information.

I agree to participate in electronic communication with Health West via text, email, and the Patient Portal.

__________ Initial

____

Signature Date

SLIDING FEE DISCOUNT APPLICATION

*** PATIENT NAME:** ____

*** PATIENT DATE OF BIRTH:** ____

***How many people are dependent on your family income?** ______________________________

***Names of people who you can claim as a dependent:** ____________________________________

____

HOUSEHOLD INCOME MUST INCLUDE:	ANNUAL GROSS HOUSEHOLD INCOME (please check one)
SALARY, WAGES, TIPS, BUSINESS PROFITS, ALIMONY, CHILD SUPPORT, SIGNIFICANT OTHER, RELATIVE, FRIENDS, RETIREMENT FUND/ SAVINGS, PENSIONS, SOCIAL SECURITY, SSDI, PUBLIC ASSIST. WELFARE, VETERAN'S ADMIN. UNEMPLOYMENT COMP., OR OTHER INCOME	____$0 - $10,000 ____$10,000 - $20,000 ____$20,000 - $30,000 ____$30,000 - $40,000 ____$40,000 - $50,000 ____$50,000 - $60,000 ____$60,000 - $70,000 ____$70,000 or above

***What is your Family's Total GROSS Income? $______________Monthly or $_____________Yearly**

____I WISH TO DECLINE AT THIS TIME:

SIGNATURE____**DATE**________________

PROOF MUST BE PROVIDED *NOTE: Valid proof may be current wage stubs, tax return, or unemployment notice. We can apply your discount up to 120 days back from the date your proof is received.*

I have read the above, and declare the information furnished by me to be true and complete to the best of my knowledge. I will notify Health West of any changes in my income, resources or family size. I also understand that this information will be treated in a confidential manner in accordance with State and Federal Law.

SIGNATURE____**DATE** _________________

____**DATE**_________________

Verified By (Staff member)

Applicant is eligible for ______% discount. **Proof has been provided? Y N**

This application will expire on ___________