HealthReach Community Health Centers

Age 0 to 11

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 insurance card is not current or available, you may be billed.			
I am the policy holder (subscriber) of this insurance on this card ❑			
My spouse ❑ Mother ❑ Father ❑ Other ❑ is the policy holder for the insurance on this card.			
Name of Policy Holder (if different than patient):		DOB:	
Mailing Address: (if different than patient):	City:	State:	Zip:

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 payors, and authorize my insurance carriers and third party payors 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:

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) and the box to the right. →	Ethnicity (√ one)
☐ Caucasian/White ☐ Native American (American Indian, Native Alaskan) ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander	Regardless of your race, do you consider yourself to be Hispanic or Latino? ◯ Yes ◯ No
Preferred Language?	**Do you need? (check if applicable)**
☐ English ☐ French ☐ Spanish ☐ Other (please specify)_____	☐ An Interpreter ☐ Sign Language

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Check ONE (if applicable)
☐ Migrant Agricultural Worker (moves from place to place for work)
☐ Seasonal Agricultural Worker (does not move for work)
Are you currently without housing (homeless)?
☐ Yes
☐ No
☐ Unknown/unreported
Have you ever served in the U.S. Military? (Air Force, Army, Coast Guard, Marines, National Guard, Navy, etc.)
☐ Yes
☐ No

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	$12,880	1	$19,320	1	$25,760	1	$25,761
2	$17,420	2	$26,130	2	$34,840	2	$34,841
3	$21,960	3	$32,940	3	$43,920	3	$43,921
4	$26,500	4	$39,750	4	$53,000	4	$53,001
5	$31,040	5	$46,560	5	$62,080	5	$62,081
6	$35,580	6	$53,370	6	$71,160	6	$71,161
7	$40,120	7	$60,180	7	$80,240	7	$80,241
8	$44,660	8	$66,990	8	$89,320	8	$89,321
For each additional person, add $4,540 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*: ☐
[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) _____

Name of Patient: _____ Date of Birth: _____