Welcome

DEMOGRAPHIC INFORMATION

Today's Date: _____

☐ New Patient ☐ Existing Patient Update

Full Name: _____ DOB: _____
(Last) (First) (M.I.)

Preferred Name: _____ SSN: _____

Marital Status: ☐ Married ☐ Divorced ☐ Domestic Partnership ☐ Single ☐ Separated ☐ Other

Physical Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street or PO Box) (City) (State) (Zip)

Contact Information:

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Preferred Phone: ☐ Home ☐ Cell ☐ Work

Primary Care Provider: _____

Employed? ☐ Yes ☐ No Employer: _____

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Guarantor Information *(person responsible for the bill, if different from patient)*:

Full Name: _____ Relationship to Patient: _____

DOB: _____ SSN: _____ Sex: ☐ Male ☐ Female

Address: _____
(Street or PO Box) (City) (State) (Zip)

Phone: _____ Secondary Phone: _____ Email: _____

Guardian Information *(if different from Guarantor)*:

Full Name: _____ Relationship to Patient: _____

DOB: _____ SSN: _____ Sex: ☐ Male ☐ Female

Address: _____
(Street or PO Box) (City) (State) (Zip)

Phone: _____ Secondary Phone: _____ Email: _____

ATTN: Please bring your insurance information to your appointment.

UDS INFORMATION

In order for Heritage Health to help our patients we must ask everyone to complete the following information. This is requested of you so that Heritage Health can receive Federal grant dollars to serve our patients and also offer other programs such as a sliding fee scale. We appreciate your cooperation. All information is kept confidential and is used for reporting purposes only.

Preferred Language: _____

Ethnic Group:
☐ Hispanic *or* Latino ☐ Non-Hispanic

Race:
☐ White ☐ American Indian *or* Alaska Native ☐ Asian ☐ Black *or* African American
☐ Native Hawaiian or Pacific Islander ☐ Unknown

Have you served in the Military? ☐ Yes ☐ No Are you a Migrant Worker? ☐ Yes ☐ No

Please indicate your Sexual Orientation:
☐ Bisexual ☐ Gay ☐ Lesbian ☐ Heterosexual (Straight) ☐ Don't Know ☐ Decline to answer
☐ Other _____

Please indicate your Sex at Birth:
☐ Male ☐ Female

Please indicate your Gender Identity:
☐ Male ☐ Female ☐ Gender Queer/Gender non-conforming
☐ Transgender: Male-to-Female/Female-to-Male ☐ Decline to answer ☐ Other _____

Current Living Status:

☐ Permanent

☐ Street (explain): _____

☐ Temporary (explain): _____

☐ Homeless (explain): _____

Family Size: _____ ☐ Decline to answer

Income: _____ ☐ Per Year ☐ Per Month ☐ Range ☐ Decline to Answer

CONSENT TO TREATMENT + OFFICE POLICIES

Please read the following information below. Your signature applies to the service rendered in conjunction with all of your visits at Heritage Health.

Patient Name:_____ DOB: _____

CONSENT TO TREATMENT: I, the undersigned, consent to outpatient care at Heritage Health, encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to: routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribed by the provider. I further consent to the performance of those diagnostic procedures, examinations and referring of medical treatment by the medical staff including physicians, nurse practitioners, physician's assistants, medical assistants or their designees as is necessary in the medical staff's judgment. I authorize Heritage Health to release any information necessary to file and settle insurance claims, including any third-party insurances. I understand I am personally financially responsible to Heritage Health for all charges not covered by assignment including co-pays, co-insurance, and ineligibility.

APPOINTMENTS & NO SHOW POLICY: Patients are required to arrive at their designated check-in time to complete the registration process. Heritage Health requires at least 24 hours' notice for any changes prior to your appointment time. As a patient if you receive 3 no-shows within a 12-month period, your account will be placed on "Walk-In Only" status for a period of 6 months. While on "Walk-In Only" status, access to appointments will be done on a walk in basis only and will be subject to available openings. Please be aware that you may be asked to wait until an opening is available, or you may be connected to our triage department for further screening.

PAYMENT: Co-pays, nominal fees, or other patient responsibility is due at the time of service. If you are unable to provide payment, arrangements will need to be made with the front desk and/or the billing department.

PRESCRIPTION REFILL POLICY: If you need a refill on a previously prescribed medication, please contact your pharmacy. The pharmacist will fax us your request along with current dosages and medications for your healthcare providers approval. Please allow 3-5 business days from the time we receive the fax from the pharmacist for your refill request to be processed.

PATIENT RIGHTS & RESPONSIBILITIES: I, the undersigned, have received the Patient Rights and Responsibilities form. I understand and agree to abide by the conditions for treatment at Heritage Health.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

Relationship to Patient: _____

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Introduction:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or sub-specialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her provider's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine

INFORMED CONSENT FOR TELEMEDICINE SERVICES

in the course of my care at any time, without effecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ (name of provider) to use telemedicine in the course of my diagnosis and treatment.

_____ _____
Patient Name (Print) DOB

_____ _____
Patient Signature Date

HIPAA
+ RELEASE OF INFORMATION

ACKNOWLEDGMENT OF PRIVACY PRACTICES: I, the undersigned, I have reviewed a copy of the Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI): This is to certify that I, the undersigned, authorize Heritage Health to disclose Protected Health Information (PHI) to family members and friends. **Please note that the below list will replace any previous authorization. List all parties you wish to grant access.** Please identify individual(s) and relationship(s):

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Print Name: _____ DOB: _____

Signature: _____ Date: _____

Relationship to Patient: _____