

Patient Name: _____

Date of Birth: _____

Pharmacy Information

Local Pharmacy Name: _____ Phone: _____

Mail Order Name: _____

List all prescription medications, over-the-counter medicines, or supplements your child is currently taking on a regular basis.

Name of Medication	Dosage	Frequency- (How many times a day)

 My child does not take any medications, over-the-counter medicine, or supplements on a regular basis.

Please complete this section for children OVER THE AGE OF 12

Tobacco: My Child

- [] Has never used any tobacco
 [] Smokes Cigarettes, Cigars, or Pipe
 [] Chews tobacco

Tobacco indicated above:

- Amount per day _____
- Started at Age _____

[] Quit using tobacco

- Date: _____

Alcohol: My Child

- [] never consumes any alcohol
 [] drinks alcohol 3 to 4 times yearly
 [] drinks alcohol once a week
 [] drinks alcohol 2 to 3 times per week
 [] Drinks alcohol daily Amount _____
 [] Beer [] Wine [] Liquor

[] Has quit drinking

- Date he/she quit drinking _____

Caffeine Use: My Child

- [] Does not drink any caffeinated beverages
 [] Drink caffeinated beverages
 • Amount per day _____

Drug Use: My Child

- [] Has never used any illicit drugs
 [] Used illicit drugs in the past
 [] Is currently using illicit drugs

- Drugs used: _____
- Date quit: _____

Female children:

- [] Is your child pregnant?
 [] Does she think she may be pregnant?
 [] Is she using contraceptives? (oral, implants, injections)
 [] Is she nursing?

Parent/Legal Guardian Signature: _____

Date: _____

Patient Name: _____**Date of Birth:** _____**AUTHORIZATION FOR TREATMENT OF MINOR**

I authorize the individuals listed below to bring my child to the office and sign for assessment and treatment of my child in the event I am unable to bring them myself.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about my child to the person(s) identified above:

Entire patient record: **or**, check **only** those items of the record to be disclosed:

office notes lab results x-rays

record of HIV and communicable disease record

hospital/nursing home/home health/hospice/and other physician records

records of mental health or substance abuse treatment

Other (please specify): _____

Limited Patient Authorization for Disclosure of Protected Health Information

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Please list the date of expiration if earlier than the end of the calendar year:

_____: Right to revoke or terminate as stated in our Notice of privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Compliance Manager. You may revoke an authorization at any time, in writing, except to the extent that your health care provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization. By initialing the following you acknowledge that you are aware of/and how to obtain a copy of the Notice of Privacy Policy, and that should you want a paper copy one can be provided at your request. It can also be viewed electronically on our website: <https://www.lifecarefhdc.org/>

Non-Conditioning Statement: The practice places no condition to sign this authorization on the delivery of health care or treatment.

Re-disclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Parent/Legal Guardian Signature: _____

Date: _____

(Must be signed and dated each year. You have a right to receive a copy of signed authorization upon request)

Patient Name: _____

Date of Birth: _____

AGREEMENT OF TREATMENT EXPECTATIONS AND MEDICAL HOME RESPONSIBILITIES

This is an agreement between two parties: the Health Center and the Patient.

The purpose of this document is a positive one. It attempts to make the clear rights and responsibilities of both parties. It says *who* is to do *what*.

A medical home is a care team working to provide you with the best care possible. We want to include you in making health care decisions. We will help you coordinate your care with providers outside of Lifecare when needed. We offer clinical advice during and after hours along with early morning appointments.

We promise to treat you to the best of our abilities, consistent with the standards of care in our community. You, in turn, promise to be as understanding, cooperative, and responsible as possible.

This Health Center has zero tolerance for violence or threat of violence of any kind. Therefore, there will not be any attempt or threat to kick, hit, or otherwise harm any staff member, patient, or visitors. Furthermore, neither party will yell or use profanity when addressing any staff member, patient, or visitors.

I have read (or have had read to me) the “Agreement of Treatment Expectations” and fully understand its contents. I have been given an opportunity to ask questions. Any violation of this agreement may result in permanent dismissal from the office.

LEGAL GUARDIAN – MUST BE COMPLETED IF PATIENT IS UNDER THE AGE OF 18

Patient Name/Legal Guardian: _____
 Social Security Number: _____ Relationship to Patient: _____
 Street Address if different from above: _____
 City, State, Zip Code: _____ County: _____

Patient/ Legal Guardian Signature : _____ **Date:** _____

Patient Name: _____

Date of Birth: _____

Financial Agreement

I hereby consent to all treatment deemed necessary by the staff of Lifecare Family Health & Dental Center, Inc. I authorize the Lifecare Family Health & Dental Center, Inc. (LIFECARE FHDC) to use, disclose, and/or receive any or all information relating to my treatment. My provider may contact any other covered entity that has provided services to me for the purpose of obtaining further diagnosis.

LIFECARE FHDC has made prior arrangements with many health plans to accept direct payments. LIFECARE FHDC will bill those plans for which it has made prior arrangement and will only require you to pay the authorized Co-pay at the time of service. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the physician or group indicated on the claim. I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my insurance. My insurance policy, if applicable, is a contract between me and my insurance company. LIFECARE FHDC is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim.

As a courtesy to the patient, LIFECARE FHDC will submit claims to any insurance company. If the patient's coverage is with a plan that LIFECARE FHDC does not have prior arrangement, the charges for the patient's care and treatment are the patient's responsibility and due in full at the time of service.

I understand that unless other arrangements have been made in advance by either me or my health coverage provider, payment is due at the time of service. For all services rendered to minors, the custodial parent or legal guardian will be responsible for all charges.

For the patient's convenience LIFECARE FHDC will accept Visa, MasterCard, Cash, and Personal Check. There will be a \$10.00 fee charged to patients for all non-sufficient funds checks and the patient will be required to pay cash for all future visits.

I further attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the number of family members listed are all solely dependent on that income. I verify my income level is truthful. I understand that LIFECARE FHDC is not in the business of extending credit and I agree to pay the above practice at the time its bill is presented. If prompt payment is not made, LIFECARE FHDC may take action to collect its charges.

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ Group#: _____
 Policyholder Name: _____ Policy Holder D.O.B.: _____
 Relationship to Patient: _____

Secondary Insurance: _____ ID#: _____ Group#: _____
 Policyholder Name: _____ Policy Holder D.O.B.: _____
 Relationship to Patient: _____

Patient Name: _____

Date of Birth: _____

Financial Agreement- continued

Lifecare receives funding to offset the costs of treating uninsured or underinsured patients. We are required to report certain demographics on all of our patients including race, family size, and income. Reporting these items assists us to receive funding to continue providing care to all of our patients. Reported information **does not** contain your name, address, or social security information.

Please circle household size and check the correct income box in the same line:

Household members	Income less than:	Income between:	Income between:	Income more than:
1	<input type="checkbox"/> \$15,060	<input type="checkbox"/> \$15,061 - \$20,783	<input type="checkbox"/> \$20,784 - \$24,849	<input type="checkbox"/> \$28,614
2	<input type="checkbox"/> \$20,440	<input type="checkbox"/> \$20,441 - \$28,207	<input type="checkbox"/> \$28,208 - \$33,726	<input type="checkbox"/> \$33,727
3	<input type="checkbox"/> \$25,820	<input type="checkbox"/> \$25,821 - \$35,632	<input type="checkbox"/> \$35,633 - \$42,603	<input type="checkbox"/> \$42,604
4	<input type="checkbox"/> \$31,200	<input type="checkbox"/> \$31,201 - \$43,056	<input type="checkbox"/> \$43,057 - \$51,480	<input type="checkbox"/> \$51,481
5	<input type="checkbox"/> \$36,580	<input type="checkbox"/> \$36,581 - \$50,480	<input type="checkbox"/> \$50,481 - \$60,357	<input type="checkbox"/> \$60,358
6	<input type="checkbox"/> \$41,960	<input type="checkbox"/> \$41,961 - \$57,905	<input type="checkbox"/> \$57,906 - \$69,234	<input type="checkbox"/> \$69,235
7	<input type="checkbox"/> \$47,340	<input type="checkbox"/> \$47,341-\$65,329	<input type="checkbox"/> \$65,330-\$78,111	<input type="checkbox"/> \$78,112
8	<input type="checkbox"/> \$52,720	<input type="checkbox"/> \$52,721-\$72,754	<input type="checkbox"/> \$72,755 - \$86,988	<input type="checkbox"/> \$86,989

REDUCED RATE PROGRAM

Lifecare offers a Reduced Rate Program as our way to offer services at a lower cost to families who meet certain requirements. The Reduced Rates are divided into different categories based on household size and gross income. Patients that qualify for the program would pay for services according to what financial category they fall into.

Are you interested in applying for our Reduced Rate Program? YES NO

I UNDERSTAND THAT THERE MAY BE CHARGES IN ADDITION TO MY COPAY BASED ON THE CLINIC'S SLIDING FEE SCALE. I AGREE TO PAY SAID CHARGES.

Patient/ Legal Guardian Signature : _____ **Date:** _____

Patient Name: _____ **Date of Birth:** _____

PATIENT DEMOGRAPHIC FORM
First Name: _____ **Middle initial:** _____ **Last Name:** _____

Date of Birth: _____ **Social Security Number:** _____

Address: _____ **Apt./Unit/Lot #** _____ **City:** _____ **Zip:** _____

Marital Status: single married divorced widowed separated

Employment Status: full time part time unemployed self-employed retired seasonal

Occupation: _____ **Education (highest grade/degree):** _____

Primary Phone Number: _____ **Additional Phone Number:** _____

Email Address _____

Preferred Contact Method: Home Phone Cell Phone Patient Portal

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

How Did You Hear About Us? (circle one from below)

Newspaper Outreach Event/Community Friend Employee of Lifecare Ad/TV/Website

Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Choose not to disclose	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female Preferred Pronouns: <input type="checkbox"/> he/him <input type="checkbox"/> she/her <input type="checkbox"/> they/them <input type="checkbox"/> Other: _____	Sexual Orientation: <input type="checkbox"/> Lesbian/Gay <input type="checkbox"/> Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else: _____ <input type="checkbox"/> Choose not to disclose
Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Choose not to disclose	Have you Served/Currently Serve in the US Military, Armed Forces, or Uniformed Services?: <input type="checkbox"/> Yes <input type="checkbox"/> No Check if any of these apply to you: <input type="checkbox"/> Homeless <input type="checkbox"/> Live in public housing Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose

Patient Name: _____**Date of Birth:** _____

HIPAA
LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED
HEALTH INFORMATION

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your last signature below unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Please list the date of expiration if earlier than the end of the calendar year:

Right to revoke or terminate as stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Compliance Officer. You may revoke an authorization at any time, in writing, except to the extent that your health care provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____: **(Initial)** By initialing the following you acknowledge that you are aware of/and how to obtain a copy of the Notice of Privacy Policy, and that should you want a paper copy one can be provided at your request. It can also be viewed electronically on our website:

<https://www.lifecarefhdc.org/>

Non-Conditioning Statement: The practice places no condition to sign this authorization on the delivery of health care or treatment.

Re-disclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient/ Legal Guardian Signature : _____ **Date:** _____

(must be signed and dated each year)

*You have a right to receive a copy of signed authorization upon request

Patient Name: _____**Date of Birth:** _____

Release Of HIPAA Protected Information

(Allow the clinic to discuss your health information with the individuals listed below)

Purpose of Request (who is authorized to receive health information) - I authorize the practice to disclose or provide health information, about me to the individual(s) listed below. (Please list each family member, friend, or other individual to receive Protect Health Information).

Name: _____

Phone Number: _____ Relationship: _____

Name: _____

Phone Number: _____ Relationship: _____

Name: _____

Phone Number: _____ Relationship: _____

Name: _____

Phone Number: _____ Relationship: _____

Description of Information to be disclosed – I authorize the practice to disclose the follow Protected Health Information about me to the person or persons identified above.

Entire patient record, **or** circle **only** those items of the record to be disclosed

Office notes lab results x-ray results

Record of HIV and communicable disease record

Hospital / nursing home / home health / hospice and other physician records

Records of mental health or substance abuse treatment.

Other (please specify): _____

Purpose of disclosure (please record the purpose of the disclosure, or check patient request):

Patient request

Other (please specify): _____

Patient/ Legal Guardian Signature : _____ **Date:** _____

(must be signed and dated each year)

Patient Name: _____**Date of Birth:** _____**Lifecare Family Health & Dental Center Appointments Contract**

Per; Lifecare Family Health and Dental Center MED 18 Attach: A

Your Lifecare Family Health & Dental Center (LFHDC), providers want to ensure that you and other area residents have access to high quality medical, dental, vision, and behavioral health care when you need it. To ensure maximum access to services for all of our patients, please be aware of the following appointment policy.

Contact Information: It is your responsibility to keep your current address and phone number on file with LFHDC. Please keep LFHDC up to date anytime your information changes.

Scheduled Appointments: Although Lifecare Family Health & Dental Center will make every effort to remind you of your upcoming appointment, however, you are ultimately responsible for remembering your appointment date and time.

Canceling Appointments: If you cannot make your scheduled appointment, you must notify us at least 4 hours prior to the appointment. Failure to provide at least four (4) hours' notice counts as a missed appointment.

Late Arrival to Appointments: Because of the critical lack of access to medical services in our area, we expect that you will arrive on time for your appointment. Should you arrive late, beyond thirty (30) minutes from your scheduled appointment time, you will then be considered as a Walk-In Status.

Walk-In status means that you could still be seen by your provider, however you will have to wait until the next available opening that day.

- If you are unable to wait, you have the option to reschedule your appointment.
- If you are late and have an appointment scheduled after 11:00am, your appointment will be at the provider's discretion for that date of service, and if they can see you later that day.
- If they are unable to see you, you will have the opportunity to see another provider that day, should there be an opening. If there is no available time on that day's schedule, you will be able to schedule an appointment for another day and time.

Please contact the health center if you have any questions about our Appointments Policy.

_____: **(Initial)** By initialing I understand and agree to abide by this Appointments Contract.

Patient/ Legal Guardian Signature : _____ **Date:** _____

(must be signed and dated each year)

Patient Name: _____**Date of Birth:** _____**DENTAL HEALTH HISTORY****Primary Care Physician:** _____ **Phone:** _____**Medical Specialists:** _____ **Phone:** _____**Pharmacy:** _____ **City:** _____ **Phone:** _____**Women only: (please circle)** Are you pregnant? Think you may be pregnant? Nursing? Taking oral contraceptives?**Have you had any major health problems in the past 5 years? (serious illness, hospitalization, surgery)**

_____**Do you have a dental emergency or major dental problem?**

_____**How long has it been since your last dental appt?** _____**Are you required to take an antibiotic before any dental treatment?** [] YES [] NO
If yes, why? _____**Do you have any of the following: (please circle)**

sensitivity hot/cold	clicking/popping of jaw	reconstructive surgery	burning tongue
bleeding/sore gums	food impaction now	biting sensitivity	periodontal surgery
swelling	grinding/clenching	headaches	orthodontics
pain in tooth now			

Allergies: Are you allergic to or have you had a reaction to: (please circle)

Penicillin	Latex	Ibuprofen	any metals
Sulfa Drugs	Local anesthetic	sedatives	food
other antibiotics	Fluoride	Aspirin	Codeine
Acetaminophen	Clindamycin		

Patient Name: _____

Date of Birth: _____

Medications: Are you currently taking any medications, over the counter drugs, or natural/herbal supplements? YES NO

medication/supplement	strength/dosage	# of times a day	reason

Do you take any blood thinners? (Plavix, Coumadin, Warfarin, or Aspirin)? YES NO

Important health information: Do you use, have, or had, any of the following? (please circle)

- | | | | |
|-------------------------|-----------------|-------------------|---------------------------------------|
| artificial joints/limbs | cancer | rapid weight loss | kidney disorder/dialysis |
| heart stents | chemotherapy | radiation therapy | neurologic disorder |
| artificial heart valves | asthma/inhalers | cleft palate/lip | narcotic use |
| pacemaker | TB | alcohol use | marijuana use |
| heart attack | arthritis | cold sores | drink cola/pop |
| stroke | systemic lupus | hemophilia | tobacco use |
| high/low blood pressure | rheumatic fever | AIDS/HIV | Type _____
How much per day? _____ |
| heart murmur | anxiety attacks | hepatitis A/B/C | _____ |
| mitral valve prolapse | eating disorder | diabetes type 1/2 | |

Reviewed with Patient:

Patient signature: _____

Date: _____

Staff signature: _____

Date: _____

Patient signature: _____

Date: _____

Staff signature: _____

Date: _____

Patient Name: _____**Date of Birth:** _____

Medical and Behavioral Health Informed Consent Agreement

Telehealth is the delivery of health care services (medical, psychiatric, therapeutic, dental) using interactive audio and visual electronic systems between a provider and a patient that are not in the physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

I consent for _____ (patient name) to engage in telehealth services with Lifecare Family Health and Dental Center. I understand and agree to the following for the duration of telehealth services with Lifecare FHDC:

1. I have the right to withhold or remove consent for telehealth services at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is confidential, just as it would be if I were in the clinic. I understand that mandated reporting laws will be followed by my provider during telehealth visits.
3. I understand that telehealth visits are transmitted via HIPAA approved platforms and that providers will take all reasonable measures to ensure that privacy is maintained during telehealth appointments. It is my responsibility to ensure that I access the internet through secure means and that I am in a private location to conduct my session to maintain privacy.
4. I understand that certain situations including emergencies and crises are inappropriate for telehealth services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433. The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
5. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and /or the electronic storage of my medical information could be accessed by unauthorized persons.
6. I understand that telehealth-based services and care may not be as complete as face-to-face services and that not all therapeutic intervention, services or patients are appropriate for telehealth services. I also understand that if my provider believes I would be better served by another form of services (e.g. face-to-face services) I will be referred to a provider who can provide such services.

Patient Name: _____**Date of Birth:** _____

7. I understand that a lack of access to all the information that might be available in a face-to-face visit, but not in a telehealth session, may result in errors in judgement. Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
8. I understand that a limited examination may take place during the videoconference and that lab and other tests are not available via telehealth.
9. I have the right to ask my health care provider to discontinue the conference at any time.
10. I understand that no part of the telehealth visit will be recorded by my provider and agree not to record any part of the visit myself.
11. I understand that my provider will document in my medical chart as if the visit were conducted in person with only the additional information required for telehealth billing.
12. I understand that I, or my insurance, will be billed as authorized by my insurance and/or sliding fee plan. I have had my questions regarding billing answered to my satisfaction by the billing department.
13. I understand that for continued telehealth services, I must be seen in person/in office at least once per year, depending on my treatment plan, diagnosis, and or medication.

I hereby consent to engaging in telehealth with Lifecare FHDC as part of my healthcare evaluation and treatment. I understand that “telehealth” includes the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communication. I have read this document and understand the risks and benefits of the telehealth services and have had my questions regarding the services answered to my satisfaction.

(Initial) Verbal Consent: In lieu of the required written consent or beneficiary signatures, verbal permission was requested and received prior to initiating the telehealth visit having covered all the items in the Informed Consent. The hard copy consent will be signed by the patient at the next face-to-face appointment.

Printed Name of Patient (or Parent/Guardian)_____
Date_____
Signature of Patient (or Parent/Guardian)