Choice Family Health Care
PATIENT INFORMATION SHEET

Please Print **Please Complete in Full**

Chart# _____

Print Name _____ Birthdate _____ Age _____
Last First Middle Maiden

Street Address _____ Home # _____ Best time

Mailing Address _____ Cell # _____ to call_____

_____ SS # _____ - _____ - _____
City State Zip Code County

I work: ☐ Full time ☐ Part time ☐ I do not work Place of Work _____

I attend school: ☐ Full time ☐ Part time U.S. Veteran Yes ___ No ___ Family member of Veteran Yes ____ No ____

Work phone _____ Best time to call _____ ☐ E-mail address _____

Emergency contact: _____ Relationship _____ Phone# _____ Cell#_____

Spouse / Partner Employment: _____ Phone # _____

I live with: ☐ Spouse / Partner ☐ Parents ☐ Others ☐ Alone

How many people live in your home? _____ How many living with you are 18 years or younger or students? _____

We must be able to contact you to give you test results. Please check all the ways we may contact you:

☐ Call home ☐ call work ☐ Mail at home ☐ Plain envelope ☐ E-mail ☐ Texting ☐ Other

How did you learn about us? ☐ Friend / Family ☐ Radio ☐ Newspaper ☐ Internet / Website ☐ Facebook ☐ Yellow Pages
☐ Billboard ☐ Other _____

Because we receive federal funds, we must collect this information about you:

Please check race: ☐ White ☐ African American / Black ☐ American Indian / Alaskan Native ☐ Asian
☐ Pacific Islander / Native Hawaiian ☐ More than one race ☐ Other

Please check ethnicity: ☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino

Are you covered by public health insurance such as Medicaid, Medicare, CHIP, TRICARE / CHAMPUS, CHAMPVA or Kids Connection? ☐ Yes ☐ No ☐ Unknown

Are you covered by private insurance? ☐ Yes ☐ No ☐ Unknown

Does your insurance cover reproductive health services? ☐ Yes ☐ No ☐ Unknown

Are you able to read written English? ☐ Yes ☐ No Are you able to understand spoken English? ☐ Yes ☐ No

Do you have an executed Advance Directive? ☐ Yes ☐ No (If yes, please provide copy)

I have been offered a copy of the Privacy Practices for Choice Family Health Care.

☐ I request a copy of the Privacy Practices. ☐ I do not desire a copy of the Privacy Practices.

☐ Bill my insurance. ☐ Bill Medicaid # _____ ☐ I do NOT wish to apply for reduced fees.

☐ I wish to apply for reduced fees and will provide complete and honest information about my income.

LIST ALL SOURCES OF FINANCIAL SUPPORT WITHIN YOUR HOME (show all amounts before any deductions)

In order to receive reduced fees, this must be filled out.

- Your employment monthly amount: _____
- Spouse / partner or parent employment _____
- Income of others 18 years or older _____
- Dependent children (AFDC / ADC) _____
- Child support and / or alimony _____
- SSI, unemployment compensation _____
- Social Security, pension, railroad retirement, insurance, annuity payments _____
- Dividends, interest, rental income, trust funds _____
- Other sources (tips, allowances, etc.) _____

How many people, including yourself, does this income support? _____

Of these persons, how may are 18 years or younger, or student? _____

Are you being claimed on your parent's tax return? ☐ Yes ☐ No

Cost for services is based on a sliding fee scale. You are responsible for any fees which may apply.

Would you like to be considered confidential for billing purposes? ☐ Yes ☐ No

Patient Signature _____ Date _____

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone with out your written consent except as may be required by law.

Office Use Only:

VERIFIED TOTAL MONTHLY INCOME_____ INCOME CODE: A(1) B(2) C(3) D(4) E(5) F(6)

CAREFUL CONTACT Yes ____ No ____ 3rd party: INS Medicaid EWM-1 EWM-2

CHOICE FAMILY HEALTH CARE
PATIENT INFORMATION & FINANCIAL POLICY

WELCOME
The staff of Choice Family Health Care (CFHC) welcomes you to our clinic. Your healthcare is our primary concern. We hope the information provided answers your questions about our services, policies, and procedures.

CELL PHONES
Out of consideration for other patients, please turn your cell phone off or put it on vibrate while you are in the clinic. IF YOU MUST TAKE A CALL while we are helping you, you may be asked to step aside while we assist the next patient, which may delay or prolong your visit to see one of our providers.

APPOINTMENTS
We strive to see all patients in accordance with their scheduled appointment. However, please understand that not all patients require the same amount of time with the provider and that emergencies do occur, so some delays are unavoidable. If and when delays occur, we will do our best to keep you informed. Your patience in these situations is greatly appreciated. In the event, you are unable to keep your scheduled appointment, you are required to notify us a minimum of two hours prior to the scheduled appointment to avoid a thirty ($30.00) No Show Fee. If you have two no shows in the same calendar year, any appointments thereafter in that same calendar year shall be on a walk-in basis only, in which you will be seen between or after other scheduled appointments are complete. If you have an unpaid balance from a previous No Show Fee or Service Fee, you shall remain on a walk-in status until your No Show and/or Service Fees are paid in full. By keeping us informed of changes in your schedule, allows the CFHC to provide our patients with quality services in a timely manner, while preventing you from being charged an additional no show fee. Title X Family Planning Services shall not be subject to any no-show fee and shall not be placed on a walk-in status.

REGISTRATION
On your visit to CFHC, you will be asked for basic information to establish your medical record and financial account. It is essential that you bring with you your current insurance information at that time and notify our office of any changes in name, address, phone number, or insurance as soon as they occur. You shall provide an active alternative contact phone number that shall be used in the event of a health emergency or financial obligations. The alternative contact phone number may be verified prior to your departure from Choice Family Health Care.

FEES
Our patients have the option to apply for reduced fees. If you wish to apply for reduced fees, you will need to supply our office with appropriate documentation of household income. If you do not provide supporting documentation, you shall be charged appropriately with the information received from your self-declaration form for up to thirty (30) calendar days. Failure to provide appropriate documentation reflecting your household income within the first thirty (30) calendar days shall result in your current and future services being billed at full pay. If you are to provide supporting documentation reflecting your household income on day thirty-one (31) or later, your charges may be re-assessed at the appropriate household income, however; a Service Fee of forty ($40.00) shall be charged. Our charges for services and office visits are based upon the complexity of services and the time spent treating you. This may include charges for testing and supplies. Clinic staff will be glad to discuss our fees with you. You shall not be denied Title X services due to the inability to pay. Title X Family Planning Services shall not be subject to any income reassessment fees. However, many primary care services shall require payment in part or in full prior to service being offered.

PAYMENT
Any patient who is unable to pay for services in full at time of delivery shall complete a Payment Agreement Plan, which shall include a specified amount to be paid at regular intervals. A statement of outstanding fees shall be sent monthly to the address you provide to us. Regardless of your medical insurance coverage, our clinic relies on you to settle this account. We are very willing to work with you on payment arrangements to help you resolve a balance and avoid collection. Our clinic accepts cash, checks and debit/credit cards as forms of payment. There is a thirty-five ($35.00) fee for all returned checks. All checks shall contain the patient's driver's license number. For account balances older than ninety (90) days, CFHC may utilize an external professional collection service to secure the remaining outstanding balance. You are ultimately responsible for all clinic fees relating to your care. Please do not hesitate to contact us to discuss your account.

DONATIONS
We are a non-profit, public health clinic. As a non-profit organization, we accept donations in support of the full range of services we provide. As required, we request you to make a donation to our agency, as all donations are tax deductible, and help us continue to serve you and other patients within our surrounding communities. Your generous donations are greatly appreciated and are applied to our general funds, unless specified otherwise. If you would like your donation restricted to a certain cause, please notify staff.

INSURANCE
CFHC accepts most medical insurance carriers, which may aid in the payment of your medical costs. Your health insurance policy is an agreement between you and your health insurance carrier. We will guide you in filing your insurance at no charge to you. Should there be any problems with an insurance claim, we request that you first direct your questions to your insurance carrier, after which our staff will be able to assist you in resolving any concerns you may have concerning your claim. However, you remain responsible for your entire balance.

THANK YOU
We appreciate you allowing CFHC to provide you the highest quality of healthcare services. We are committed to you to be the very best and providing you quality healthcare services at affordable rates. Our staff is pleased to work with you and be a lasting partner in your healthcare needs. We take great pride in our training, abilities, and dedication to all of our patients. You input provided in the satisfaction surveys help us grow as a Center that serves your individual needs. If you should ever have any questions or concerns, we encourage you to bring those to our attention in a professional manner where we can attempt to resolve them in a timely manner.

_____ _____

Patient Signature Date

CHOICE FAMILY HEALTH CARE
PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices for Choice Family Health Care and I have been provided an opportunity to review it. I acknowledge the information below is a brief summary of the Privacy Practices given me.

Name: _____ **Pt. #:** _____ **Birthdate:** _____

Signature: _____ **Date:** _____

ASSURANCE OF CONFIDENTIALITY:

Your medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Nebraska partnership for Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of it's legal duties and privacy practices with respect to Protected Health Information.

Choice Family Health Care may access, use and share medical information for purpose of:

- Treatment
- Payment
- Operations

Other permitted uses and disclosures that may be made without consent may be those for:

- As Required By Law
- Public Health Activities
- Communicable Diseases
- Health Oversight
- Abuse or Neglect
- Legal Proceedings
- Law Enforcement
- Workers Compensation
- Research
- Coroners, Funeral Directors, And Organ Donation
- Criminal Activity
- Military Activity and National Security
- Food and Drug Administration
- Inmates
- Required Uses and Disclosures for Investigative Compliance Reasons

Your rights to privacy:

- Right to Inspect and Copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions (CFHC is not required to agree)
- Right to Request Confidential Communications

Choice Family Health Care reserves the right to amend its Privacy Practices at any time and will provide notice of any material change or revision of these practices.

I understand my written consent is required for the release of my medical information, except as may be necessary to provide services to myself or as noted above with appropriate safeguards for confidentiality. When information is requested, CHC shall release only the specific information requested. Information collected for data reporting purposes will be disclosed only in summary, statistical, or other form, that does not identify particular individuals. Upon signed written request, patients transferring to other providers may have their records transferred to expedite continuity of care.

You can also provide us written authorization to use your medical information for other purposes; you may revoke that permission, in writing, at any time.

Grand Island
217 E. Stolley Park Rd, Ste E
Grand Island, NE 68801
PH 308-384-7625
FX 308-384-8904

Kearney
4503 2nd Ave Ste 209
Kearney, NE 68848
PH 308-234-9140
FX 308-236-5814

CHOICE FAMILY HEALTH CARE

Male Medical History

Patient Name: _____ **Date:** _____ **Chart #:** _____

Reason for Visit: _____ **Allergies:** _____

DOB: _____ **Occupation:** _____ **Family Doctor:** _____

Current Medications: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated Living with Someone Yes No

Are you a student: _____Yes _____No

Highest Grade in School Completed: _____

Insurance: _____ **Secondary Insurance :** _____

Please answer the following questions. This will help your physician identify possible problems:

Age: _____

Type of Sexual partner? _____Same Sex _____Opposite Sex _____Both

# of Sexual Partners Within last 3 months: _____ **# of Sexual Partners Within last 12 months:** _____

Are you sexually active? ____Yes _____No

When sexually active, do you use birth control? ____Yes ____No **Birth control method used?** _____

Have you ever been abused? ____Yes _____No **Do you feel safe at home?** _____Yes ____No

Has someone forced you to have sex? _____Yes ____No

Do you smoke? ____Yes _____No **If yes, how many cigarettes per day?** _____

Family History:	**Mother**	**Father**	**Siblings**	**Grandparents**
Heart Problems	Yes No	Yes No	Yes No	Yes No
Colon Cancer	Yes No	Yes No	Yes No	Yes No
Other Cancer	Yes No	Yes No	Yes No	Yes No
High Cholesterol	Yes No	Yes No	Yes No	Yes No

Health Habits: *Fill in all blanks*

Do you Exercise? Yes No
Do you Drink Water? Yes No
Wear your seatbelt? Yes No
Drink Caffeine? Yes No # per day _____
Drink Alcohol? Yes No # per day _____
Recreational Drug Use? Yes No Type_____
IV Needle Use? Yes No

Personal History: *Please circle all that apply to you today*

Generally overall good Health	Unexplained weight loss or gain	Cold Symptoms	Chest Pain
Swelling in arms or legs	Abdominal Pain	Rectal Bleeding	Constipation
Headaches	Shortness of breath	Diarrhea	Penile Lesions
Blood in Urine	Urinary Burning	Penile Discharge	Rash in Genital Area
Yellowing of Skin	Blisters	Warts	Anemia
Yellowing of eyes	Earache R L	Sore Throat	Cough
Muscle Pain	Rash	Tooth/Gum Pain	Anxiety
Depression	Enlarged Prostate	Erection Problems	

To the best of my knowledge, the above history is complete and accurate. I understand the educational information give to me. I have been given an opportunity to ask questions. If I am 19 years old or younger, I have been strongly encouraged to discuss my family planning needs with my parents and I have received information on abstinence and how to resist sexual pressure. If I smoke, I have given information and understand the health risks of smoking. I have been told that if tests are taken for sexually transmitted infections (STI), reporting of positive results to public health agencies is required by law. I understand that Nebraska Health and Human Services may access my medial record to determine the quality of services provided by this agency.

CONSENT TO TREATMENT: I hereby consent to examination, consultation, testing, including HIV testing, and treatment at this clinic. If I do not want testing for HIV, I will notify personnel at CFHC that I do not want to be tested for HIV.

⇒ Waiver Form Signed ***(DO NOT SIGN UNTIL INSTRUCTED BY STAFF AS WITNESS)***

Patient Signature: _____ **Staff Signature:** _____ **Date:** _____

Patient Name: _____

Birth Date: _____

Patient Number: _____

CHOICE FAMILY HEALTH CARE

HIV Waiver Form

The 2006 revised CDC recommendations for HIV Testing for Adults, Adolescents, and Pregnant Women in Health-Care Settings advocates for routine voluntary HIV screening as a normal part of medical practice, similar to screening for other treatable conditions. Screening is a basic public health tool used to identify unrecognized health conditions so treatment can be offered before symptoms develop and, for communicable diseases, so interventions can be implemented to reduce the likelihood of continued transmission.

HIV infection is consistent with all generally accepted criteria that justify screening: 1) HIV infection is a serious health disorder that can be diagnosed before symptoms develop: 2) HIV can be detected by reliable, inexpensive, and noninvasive screening tests; 3) infected patients have years of life to gain if treatment is initiated early, before symptoms develop; and 4) the costs of screening are reasonable in relationship to the anticipated benefits. Among pregnant women, screening has proved substantially more effective than risk-based testing for detecting unsuspected maternal HIV infection and preventing perinatal transmission.

However, for the following reason/s indicted I, _____, decline to be tested for HIV:

- ☐ I do not feel that I am at risk for having HIV
- ☐ I am afraid of finding out whether I may have HIV
- ☐ I am afraid of my partner finding out I was tested and/or what he/she might do to me
- ☐ I am concerned with telling my partner I was tested and losing his/her trust
- ☐ I am concerned of what my health insurance company would do if I am HIV positive
- ☐ I was recently tested and have had no new partners or risk behaviors within the past 3 months
- ☐ I want to wait until adequate time has lapsed since my last unprotected risk to be able to detect the virus

_____ _____

Patient Signature Date

Staff Initials: _____