219 Health NETWORK

Today's Date: ______________________ Date of Birth: ______________________

Patient Legal Name:	Social Security:
Patient Preferred Name:	US Resident: Y / N Refugee: Y / N Country of Origin:
Address:	Telephone:
City: State: Zip Code:	Township/County:
Email address:	Veteran: Y / N Discharged: Y / N Date of Discharge: / /
Emergency Contact: Relationship:	Telephone:

List all individuals living in household (list each separately, INCLUDING THE PATIENT):

Name	M/F	Age	Date of Birth	Relation	SSN

Gender Identity	
Male	
Female	
Transgender Male/ Female-to-Male	
Transgender Female/ Male-to-Female	
Other	
Declined to answer	

Sexual Orientation	
Straight	
Gay	
Lesbian	
Bisexual	
Other	
Unknown	
Declined to answer	

Homeless	
Homeless Shelter	
Public Housing	
Transitional	
Doubling Up	
Street	
Other	
Unknown	

Primary Language	
English	
Spanish	
Other	
Do you need an interpreter?	

Marital Status	
Single	
Married	
Separated	
Divorced	
Widowed	

Employment	
Full Time	
Part Time	
Self-Employed	
Retired	
Seasonal Worker	
Mirgrant Worker	
Unemployed	

Race	
Black/African-American	
Asian	
Native Hawaiian	
Other Pacific Islander	
American Indian/Alaskan National	
White	
More than one race	
Refused	

Ethnicity				
Are you Hispanic/Latino?	Yes		No	

Preferred Communication Method					
Mychart		Email		Voice	

Annual Household Income	
$0 - 20,000	
20,001- 50,000	
50,001 - 100,000	
100,001+	

House Hold Size:

Insurance	
Patient Refused Intake	
Uninsured	
Medicare	
Medicaid	
Medicaid Pending	
HIP	
Private Insurance	

Preferred Pharmacy

Address:

It is my responsibility to keep 219 Health Network informed of any change in address, phone number, income, and/or health coverage.

I understand that the information which I submit is subject to verification by 219 Health Network, federal and/or state enforcement agencies, and others as required. Under penalty of perjury and/or fraud, I affirm that the above information is true and correct.

___________________________________ ___________________________________

Applicant (signature) ***Applicant*** (printed name)

219 Health NETWORK **PT. NAME:** **MRN #:**

Consent: To provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initialing the areas indicated and/or by provided your signature below.

Release of Information: I authorize the below names to receive information from 219 Health Network relating to any part of my care (or that of my dependent), to schedule/reschedule/cancel appointments on my behalf (or that of my dependent), and in my absence, the below person(s) can consent to care and treatment of my minor dependent. I understand this information may include drug and alcohol, mental health, HIV/AIDS test results and/or genetic testing, and this authorization is valid unless cancelled by me in writing.

I, ______________________ (____ Self; ____ Parent; ____ Legal Guardian), give my permission for:

Name: ______________________ Relationship: ______________ Phone: ______________

Name: ______________________ Relationship: ______________ Phone: ______________

Name: ______________________ Relationship: ______________ Phone: ______________

I understand that this consent will expire after one year and may be revoked anytime during this year. To end this consent 219 Health Network must be notified in writing by the patient or the legal guardian of the patient. ________ **(initials)**

I would like 219 Health Network to leave a voicemail with test results. ________ **(initials)**

Consent of Treatment:
I consent to necessary care by my provider and agree to comply with the treatment plan. If I do not comply with the treatment plan, 219 Health Network may choose not to provide further care. ________ **(initials)**

Statement of Agreement:
I have been advised of my rights and obligations related to 219 Health Network's Policies and Procedures. ________ **(initials)**

Notice of Privacy Practices:
219 Health Network is committed to protecting your personal health information in compliance with the law. A copy of the Notice of Privacy Practices is available upon request.

Patient Bill of Rights:
Our mission at 219 Health Network is to treat all patients with respect and dignity regardless of the patient's socio-economic status. 219 Health Network's Patient Bill of Rights is posted for review and is available upon request.

Signed: ______________________________ **Date:** ______________

Parent/Patient's Representative (if a dependent) ______________________ Date: ______________

Relationship: ______________________________

Co-payments: I understand that if my medical insurance requires a co-pay or encounter fee the payment is due AT THE TIME OF SERVICE.

Precertification: If my insurance requires precertification it is my responsibility to make sure it is obtained. I will be held financially responsible if the precertification is not obtained.

Advance Directive: Information regarding advance directives is provided in the Patient Information Guide.

ADVANCE DIRECTIVE

Have you appointed a Health Care Representative? yes ____ no ____ Do you have a living will? yes ____ no ____

Have you given anyone your Power of Attorney? yes ____ no ____