Patient Information Sheet

Welcome to Jordan Valley Community Health Care!

To protect the privacy of your information…….

PLEASE DO NOT REMOVE THIS COVER PAGE

Please return your completed forms with this sheet face up, to our trusted team.

Thank you!

Patient Name: _____

Patient Date of Birth: _____/_____/_____

Thank you for choosing Jordan Valley Community Health Center. We ask for this information to meet reporting requirements of programs who help support Jordan Valley and to better provide care based on your likes and needs.

Patient Last Name | Patient First Name | Middle Name | Preferred Name

Street Address | City | State | Zip

( ) - | ( ) - | Email Address

Preferred Phone | Secondary Phone

- - | / / |

Social Security Number | Date of Birth

What is your preferred language? _____

Sex at Birth: ☐ Female ☐ Male ☐ Decline to Specify

Ethnicity: ☐ Latino or Hispanic ☐ Not Latino or Hispanic

Race:

☐ American Indian / Alaska Native ☐ Black/African American ☐ Native Hawaiian / Pacific Islander

☐ Asian ☐ More than one race ☐ White

Housing Status:

☐ Doubling Up ☐ Shelter ☐ Transitional

☐ Not Homeless ☐ Street

For patients aged 12 years and older:

Gender Identity:

☐ Female ☐ Transgender Female ☐ Genderqueer

☐ Male ☐ Transgender Male ☐ Decline to specify

Sexual Orientation:

☐ Heterosexual ☐ Bisexual ☐ Decline to specify

☐ Homosexual ☐ Don't Know

Preferred Pronoun:

☐ He / Him / His ☐ They / Them / Their

☐ She / Her / Hers ☐ Other: _____

For patients aged 18 years and older:

Marital Status:

☐ Married ☐ Single ☐ Life Partner

☐ Divorced ☐ Widowed ☐ Decline to Specify

Highest level of completed education:

☐ Grade school ☐ Some College ☐ Advanced Degree

☐ Some High School ☐ Associate Degree ☐ Other:

☐ High School Graduate or GED ☐ Bachelor Degree

Employment Status:

☐ Full-time ☐ Retired ☐ Student

☐ Part-time ☐ Disabled ☐ Unemployed

Are you a Veteran of the US Armed Forces? ☐ Yes ☐ No

Patient Name: _____

Patient Date of Birth: _____/_____/_____

Please circle the box that best represents your household's total income range based on household family size:

Family Size	A	B	C	D	E
1	$0 – $12,760	$12,761 – $19,140	$19,141 - $22,330	$22,331 - $25,520	$25,521 or greater
2	$0 – $17,240	$17,241 – $25,860	$25,861 – $30,170	$30,171 – $34,480	$34,481 or greater
3	$0 – $21,720	$21,721 – $32,580	$32,581 – $38,010	$38,011 – $43,440	$43,441 or greater
4	$0 – $26,200	$26,201 – $39,300	$39,301 – $45,850	$45,851 – $52,400	$52,401 or greater
5	$0 – $30,680	$30,681 – $46,020	$46,021 – $53,960	$53,691 – $61,360	$61,360 or greater
6	$0 – $35,160	$35,161 – $52,740	$52,741 – $61,530	$61,531 – $70,320	$70,321 or greater
7	$0 – $39,640	$39,641 – $59,460	$59,461 – $69,370	$69,371 – $ 79,280	$79,281 or greater
8	$0 – $44,120	$44,121 – $66,180	$66,181 – $77,210	$77,211 – $ 88,241	$88,241 or greater
9	$0 – $48,600	$48,601 – $72,900	$72,901 – $85,050	$85,051 – $97,200	$97,201 or greater
10	$0 – $53,080	$53,081 – $79,620	$79,621 – $92,890	$92,891 – $106,160	$106,161 or greater

Please enter your health insurance(s) (including Medicaid or Medicare) information below.

Primary Medical Insurance	**Secondary Medical Insurance (if applicable)**
Insurance Name	Insurance Name
Member ID or DCN	Member ID or DCN
Policy Holder Name (Primary Insured)	Policy Holder Name (Primary Insured)
Policy Holder SSN	Policy Holder SSN

Dental Insurance	**Vision Insurance**
Insurance Name	Insurance Name
Member ID or DCN	Member ID or DCN
Policy Holder Name (Primary Insured)	Policy Holder Name (Primary Insured)
Policy Holder SSN	Policy Holder SSN

☐ I do not have insurance at this time.

Guarantor: A guarantor is the person who agrees to make payment on the patient's behalf when the patient can't guarantee payment on their own. Dependent minors under the age of 18 years or adults with legal guardians must have an alternative guarantor named. If needed, please name a guarantor below:

Last Name First Name Middle Name

Street Address City State Zip

( ) - - - / /

Phone Social Security Number Date of Birth

JVCHC will confirm your current Medicaid, Medicare, or other insurance plan/benefit at each visit. Please share with us your current benefits card. Not all health insurance plans are accepted at JVCHC. We'll confirm if your plan is accepted. If your plan denies payment for your services, you are responsible for the balance due.

JVCHC *does not* file liability insurance, such as motor vehicle or third party coverage. We also do not file workers' compensation claims. JVCHC will share information with you if you choose to file your own claims for this coverage.

JVCHC offers a pre-paid discount or a sliding fee discount for uninsured patients. Full payment of copays, deductibles, and/or sliding and other fees owed is due at time of service. Past due payments can may be referred to a collection agency. JVCHC offers payment agreements to help you. If a balance remains unpaid, patients may be limited from accessing services at JVCHC.

Patient Name: _____

Patient Date of Birth: _____/_____/_____

Acknowledgement of Patient Practices

Keeping Your Appointments
It's important you keep your appointments to stay healthy. If you can't keep your appointment, please call us right away, but no less than 24 hours before your appointment. If you miss too many appointments, JVCHC may limit how you can schedule in the future.

Understanding *Patient Rights and Responsibilities*
JVCHC upholds certain rights to patients while asking patients to carry out certain responsibilities to help assure good health care. The *Patient Rights and Responsibilities* statement is posted publicly in our clinics. You can request a complete print copy of *Patient Rights and Responsibilities* at any time within our clinics.

Acknowledgement of *Notice of Privacy Practices*
JVCHC may sometimes use or disclose limited protected health information (PHI) about your medical, dental, vision, or behavioral health care with other entities to coordinate your care, assure payment for services, or to support health care operations. Some examples of this disclosure include submission of electronic prescriptions on your behalf, billing and/or payment data shared with third-party service vendors, and contact information for appointment reminders or feedback requests. Additionally, JVCHC may use or disclose your PHI without authorization when there is an emergency or when JVCHC is required by law to do so.

Generally, other uses or disclosures of your PHI can only be done with your written authorization. Review our *Notice of Privacy Practices* to learn how protected health information about you may be used and disclosed and how you can get access to this PHI.

A complete *Notice of Privacy Practices* is provided to all patients at their first appointment, is posted in publicly accessible areas of JVCHC's clinics, and can be found on JVCHC's website (www.jordanvalley.org). You may request a complete copy of the *Notice of Privacy Practices* at any time within our clinics.

Limited Verbal Release of Protected Health Information
JVCHC gives you the option to name other persons who can contact JVCHC to talk about your (or your dependent's) care, treatment, payment, or appointment schedules. These persons can't make decisions about your (or your dependent's) care. JVCHC will ask these persons to identify themselves before sharing PHI. PHI will not be shared with persons who are not authorized by you.

I authorize limited release of my PHI as told above to the following person(s):

Full Legal Name	Relationship	Date of Birth	Phone
		/ /	( ) - -
Full Legal Name	Relationship	Date of Birth	Phone
		/ /	( ) - -
Full Legal Name	Relationship	Date of Birth	Phone
		/ /	( ) - -
Full Legal Name	Relationship	Date of Birth	Phone

Consent for Treatment
By signing below, **I am giving consent for myself/my dependent to receive any treatment or procedure** deemed necessary by the professional staff of JVCHC which may include medical, dental, or behavioral health treatment. By signing below, I hereby state that I am the parent, primary legal custodian, or joint legal custodian of the patient being presented today for treatment. Behavioral health and education services are documented in the electronic medical record and are available for your primary care providers to view. Additionally, your insurance company may require basic information about you such as diagnosis and how many appointments you have had. Other than this, your information is kept confidential unless you disclose intent to harm yourself or another person, or that you are aware of abuse to child, elderly or otherwise vulnerable adult. These situations will have to be reported to the appropriate authorities. **I also acknowledge the above notices, permit limited release of my PHI as described, and agree to payment of services.**

Print Patient Name

Patient / Legal Guardian Signature

/ /
Date

Print Legal Guardian Name (if applicable)

Patient Name: _____

Patient Date of Birth: _____/_____/_____

Consent to Exchange Health Records via Midwest Health Connection (MHC)

Midwest Health Connection (MHC) is a health information exchange network that enables the efficient sharing of your health information amongst its participating providers and other organizations to provide treatment to you, payment for your care, and for other lawful purposes. Sharing this information can help your providers continue your care based on your medical history. Jordan Valley Community Health Center (JVCHC) uses MHC's services to share and receive information about its patients.

You can choose to if you want to participate in the health information exchange. The care you receive from providers at JVCHC is not dependent on whether or not you choose to participate in the health information exchange. With this form you may choose from 2 options:

1) **Opt- in:** With this option you confirm your consent for JVCHC to share your health records maintained by JVCHC through the MHC health information exchange, and for other MHC network participants to access your JVCHC records for treatment, payment, health care operations, and other lawful purposes.

2) **Opt-out:** With this option you understand that although you are choosing not to participate in the health information exchange, your health information may still be disclosed to MHC, but the MHC health information exchange will not permit your health information to be further viewed by or shared, unless you later provide your consent.

If you confirm your consent to **Opt-in**, you provide permission for:

- JVCHC to share all of your available health records through the MHC health information exchange network participants, including those created on, before, and/or after today's date.
- JVCHC to use or share your health records as allowed by federal and state laws.
- JVCHC to share health records containing sensitive information about your HIV/AIDS status, mental health, developmental disabilities, sexually transmitted diseases, head and spinal cord injuries, genetic diseases or tests, and family planning care including abortions through MHC.
- JVCHC to share health records related to your substance use disorder treatment, if any, through MHC. Such information may include, but is not limited to: diagnostic information; medications and dosages; substance use history and summaries; employment information; and living, housing, and social history. Such information will only be shared with health care providers that you have a treating provider relationship with that participate in the MHC health information exchange. A list of the current health care providers and/or organizations who may access your health records with MHC is available for review at https://mhc-hie.org/. The list of participating providers and/or entities may change at any time without notice.
- JVCHC to copy or include your health data in JVCHC's health records.

MHC and JVCHC assure certain information availability and protections for patients who consent to **Opt-in** to the MHC health information exchange:

- Neither MHC nor JVCHC will use your health records for advertising nor to determine eligibility for insurance, slide program, or employment.
- MHC maintains records of the authorized persons and/or organizations who access your health records. You may request a report of who has accessed your records from MHC.
- Consent to allow JVCHC to share your health records is voluntary. You can revoke your consent at any time by completing a revocation form available to you at JVCHC or by opting out of MHC at another MHC participating provider. If you revoke consent, JVCHC and other MHC participating providers are not required to remove health records that were copied/retained prior to your revocation.
- Consent to allow JVCHC to share your health records will remain in effect until the day you revoke your consent by completing a revocation or opt-out form or the day in which MHC no longer exists, whichever comes first.
- MHC and JVCHC maintain policies related to enforcing penalties against persons who may access or share your information in the wrong way.

Patient Name: _____

Patient Date of Birth: _____/_____/_____

Option 1:

☐ By signing below, **I choose to Opt-in** to the health information exchange**; I give my consent** for JVCHC to share all available health records about me (or patient ward) through the MHC health information exchange.

Print Patient Name

Patient / Legal Guardian Signature — Date: / /

Print Legal Guardian Name (if applicable)

JVCHC Witness: Print Name — Date: / /

- - - - OR- - - - -

Option 2:

☐ By signing below, **I am choosing to Opt-out** of the health information exchange. I understand by opting out of the MHC health information exchange I am requesting that none of my health information be shared through the MHC health information exchange. I understand that although I am choosing to opt-out of the health information exchange, my health information may still be disclosed to the MHC, but the MCH health information exchange will not permit my health information to be viewed by or shared with any participating providers.

Print Patient Name

Patient / Legal Guardian Signature — Date: / /

Print Legal Guardian Name (if applicable)

JVCHC Witness: Print Name — Date: / /

☐ I chose to take this information home and will make a decision at a later time. I understand that by not signing this form today / / , a Notary Public will need to sign and stamp this form at the time I select to either opt-in or opt-out of participation in the health information exchange.

This area to be completed by a Notary Public:

The foregoing instrument was acknowledged before me, a Notary Public, on _____(date), by _____ (patient/legal authority name), known to me to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained.

Notary Signature: _____ State: _____ County: _____

Notary Stamp: