Pueblo Community Health Center
Your Health. Our Mission.

Patient Information Form

PLEASE PRINT (**ONE** form per person)

Date: _____

Patient Information

Legal Name: Last _____ First _____ M.I. _____

Birth Date: ____/____/_____ Social Security # _____-_____-_____

Sex: ❑ Male ❑ Female ❑ Transgender Male/Female-to-Male ❑ Transgender Female/Male-to-Female ❑ Other ❑ Decline

Physical Address:_____City:_____ State: _____ Zip:_____

Mailing Address: _____City:_____ State: _____ Zip:_____

Phone(s): Day: (____)_____-_____ Cell : (____)_____-_____ Email address: _____

Employer: _____ Work Number: (____)_____-_____

Guarantor Information (Person Responsible for Payment of Accounts/Services)

Same as above ☐

Legal Name: Last _____ First _____ M.I. _____

Birth Date: ____/____/_____ Social Security # _____-_____-_____ Relationship to Patient: _____

Mailing Address: _____City:_____ State: _____ Zip:_____

Phone(s): Day: (____)_____-_____ Cell: (____)_____-_____ Email address: _____

Employer: _____ Work Number: (____)_____-_____

Person to Notify in Case of Emergency (Spouse, Parent, Guardian or Other)

Name: _____Relationship to Patient: _____ Phone: (___) _____-_____

Insurance Information
(Provide current copy of insurance card to PCHC staff)

Name of Insured: _____Name of Insurance_____

Policy Number: _____ Group Number: _____ Policyholder Name: _____

Effective Date: _____ Patient's Relation to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policyholder SSN#:___/_____/_____ Policyholder DOB: _____

Secondary Insurance Name: _____ ID# _____

Is your visit due to a(n): Auto Accident? ☐ Yes ☐ No Job Related Injury? ☐ Yes ☐ No

Household Income Information

Number of People Living in Household: _____

Estimated Monthly Household Income: $_____ (If no income, please enter "0")

See Back

Additional Information
Please answer the following questions in order for us to better serve you.

What language is preferred? ☐ English ☐ Spanish ☐ Other _____

Over the past 24 months, have you (patient) or a member of your family:

Been hired to do agricultural work like: planting, picking, packing house, driving truck for any type of farm work, worked with animals like cows, chickens, etc.? ☐ Yes ☐ No

Lived away from home in order to work in any type of agriculture (farm work)? ☐ Yes ☐ No

Stopped working in agriculture because of disability or age (too old to do work)? ☐ Yes ☐ No

Are you presently living with friends or family, in your car, in a shelter, in a hotel or on the street and consider yourself homeless? ☐ Yes ☐ No

US Veteran Status: Have you (patient) completed service in the Uniformed Services of the United States? ☐ Yes ☐ No

Ethnicity: Check one of the following ethnic groups that best pertains to you (patient).

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Race: Check one of the following racial groups that best pertains to you (patient).

☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black/African American (including Blacks or African American of Latino/Hispanic descent)
☐ American Indian/Alaska Native (including American Indians or Alaskan Natives of Latino/Hispanic descent)
☐ White (including Whites of Latino/Hispanic descent)

Marital Status:

☐ Married (Common Law)
☐ Single
☐ Widowed
☐ Divorced
☐ Other _____

Sexual Orientation:

☐ Lesbian or Gay
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't know
☐ Decline to disclose

I hereby certify the information provided is correct and true to the best of my knowledge. I permit PCHC representatives to contact any necessary person or agency to verify this information. I agree to notify PCHC promptly of any change in household members, address, phone, income, insurance, or other essential information. I understand that I must show my card at time of service based upon the guidelines established by PCHC and the State of Colorado. Co-payments/nominal fees are to be made at time of service unless authorized beforehand.

I understand PCHC may request additional information from me in the future to qualify me for programs that will help cover the costs of my care, prescriptions and other services while I am a PCHC patient.

X_____ Date: _____/_____/_____

Signature of Patient (If patient is over 18), GUARDIAN (If patient is under age 18, OR WITNESS (If adult patient is unable to sign)

Print Name: _____

Relationship to Patient: ☐ Self ☐ Parent/guardian ☐ Authorized Representative ☐ Other: _____

How did you hear about PCHC?

☐ Family/Friend
☐ Radio/TV
☐ Social Media
☐ Walk-In
☐ Billboard
☐ Other: _____

Authorized Use Only

Staff initials: _____ Dept: _____

New patient: Yes ☐ No ☐

FPT ☐ FHT ☐ IZ's ☐ AAA Dental ☐ OB Care Only ☐ Podiatry Only ☐

DDS Only ☐ EIS Only ☐ NFP Only ☐ Nursing Home Only ☐

Revision date: 6/2018

Pueblo Community Health Center
Your Health. Our Mission.

Supplemental Information Form - Minors

PLEASE PRINT (**ONE** form per minor)

Date: _____

Patient Information

Legal Name: Last _____ First _____ M.I. _____

Birth Date: ____/____/_____

Parent Information

1st Parent Name/ Guardian: Last _____ First _____M.I. _____

Birth Date: ____/____/_____ Relationship to Patient: _____

Phone(s): Day: (____)_____-_____ Cell: (____)_____-_____

Secondary Contact Number: (____)_____-_____

2nd Parent Name/ Guardian: Last _____ First _____ M.I. _____

Birth Date: ____/____/_____ Relationship to Patient: _____

Phone(s): Day: (____)_____-_____ Cell: (____)_____-_____

Secondary Contact Number: (____)_____-_____

Delegated Consent to Treat

Please complete this section if you to appoint a person(s) to bring minor in for appointment.

I (We) _____ and _____
Parent/Guardian Name Parent/Guardian Name

hereby state that I/we, the parent(s) or legal guardian(s) of _____, a minor, born on _____
Minor child's name DOB

authorize _____ , _____, _____, (Assigned Person(s) Name), an adult, to consent to any necessary examination, medical diagnosis or treatment to be rendered to the above named minor under the general or special supervision and on the advice of any provider licensed to practice at Pueblo Community Health Center.

Signature of Parent/Guardian _____ Date_____

Authorized Use Only

Staff initials: _____ Dept: _____

Creation date: 8/2019

HIPAA Acknowledgement & Confidential Communication Request

Date: _____ **Patient Name:** _____

Patient DOB: _____

ALL NEW PATIENTS MUST COMPLETE THIS FORM.

ACKNOWLEDGEMENT

I _____ (Patient Name) acknowledge receipt and reviewed the Pueblo Community Health Center Notice of Privacy Practices (please sign below).
I would like to receive a copy of any amended Notice of Privacy Practices by email: ___Yes ____No
If yes, please provide email address: _____

COMMUNICATION

I also would like Pueblo Community Health Center to follow these instructions when contacting me regarding my health care (please mark all that apply):

At day phone number listed (preferred contact number):

Leave messages on my answering machine/voice mail __ Allow ___ Not allow
Leave messages with any other person __ Allow ___ Not allow

At alternate phone number: (_____) _____-_____

Leave messages and tell them who is calling if asked __ Allow ___ Not allow
Leave messages on alternate phone voice mail or answering machine __ Allow ___ Not allow

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Signature of Patient/Guardian: _____ Date _____

Parent/Guardian Name (Please Print): _____

If not signed by patient (or plan member), please complete section below and indicate your relationship:

____ Parent/Guardian of minor patient.
Mother's Name: _____ Father's Name: _____
____ Beneficiary or personal representative of deceased patient (Copy of court order needed)
____ Guardian or Conservator of an incompetent person (Copy of court order needed)
____ Other (specify) _____

Privacy Practice Acknowledgement must be signed before initial visit to Pueblo Community Health Center. You may end or change "Communication" section in this form at any time by filling out a new form. All previous "HIPAA Acknowledgement & Confidential Communication Request" forms will be void.

Staff Initials: _____ Dept: _____

Date sent to Med Rec: _____ Med Rec Clerk Initials: _____ Scanned Date: _____

HIPAA Acknowledgement & Confidential Communication Request

Date: _____ **Patient Name:** _____

Patient DOB: _____

PATIENT WILL COMPLETE UPON REQUEST

AUTHORIZATION

I, _____, give my permission to Pueblo Community Health Center and/or any staff member of Pueblo Community Health Center, to discuss my health care with the individuals noted below who may, from time-to-time, help me receive and pay for health care. This may include, but is not limited to, attending my appointments, helping me follow treatment recommendations, picking up medicines, helping me understand my test results, helping me understand and make payments for health care

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Please note: This form does not replace the Release of Information form that must be completed to release PHI to another entity (person/business).

RESTRICTIONS

The following people shall not be allowed access to my Personal Health Information:

Name_____ Relationship_____

Name_____ Relationship_____

Signature of Patient/Guardian: _____ Date _____

Parent/Guardian Name (Please Print): _____

If not signed by patient (or plan member), please complete section below and indicate your relationship:

____ Parent/Guardian of minor patient.
Mother's Name: _____ Father's Name: _____
____ Beneficiary or personal representative of deceased patient (Copy of court order needed)
____ Guardian or Conservator of an incompetent person (Copy of court order needed)
____ Other (specify) _____

You may end or change the directions in this form at any time by filling out a new form. All previous "HIPAA Acknowledgement & Confidential Communication Request" forms will be void.

Staff Initials: _____ Dept: _____

Date sent to Med Rec: _____ Med Rec Clerk Initials: _____ Scanned Date: _____

Pueblo
Community
Health Center

Consent to Treat/Bill
(Please complete one form per patient)

I authorize release of Protected Health Information necessary to obtain payment, provide treatment and to conduct healthcare operations as described in PCHC's Notice of Privacy Practices.

I consent for the clinician to treat my medical, behavioral health and/or dental condition.

I authorize payment of benefits to PCHC for services rendered and agree to pay all balances due, including collection costs.

I consent to be contacted by regular mail, by email or on my phone (including my cell phone) regarding any matter related to any account where I am the guarantor at PCHC, its successors, or outside agency as assigned by PCHC. This consent includes any updated or additional contact information that I may provide and includes phone calls that employs auto-dialer technology and prerecorded messages. This consent applies to all PCHC healthcare providers. If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by mailing such revocation to Pueblo Community Health Center, 110 E. Routt Ave., Pueblo, CO 81004.

_____ _____
Patient Name (Please Print) Patient DOB

_____
Patient Signature

_____ _____
Parent/Guardian Signature Parent/Guardian Name (Please Print)

_____
Date Signed

Consent to Treat/Bill must be signed annually by patient.

AUTHORIZED USE ONLY

Staff Initials: _____ Dept: _____

Date sent to Medical Records: _____ Med Rec Clerk Initials: _____ Scanned Date: _____

Pueblo Community Health Center
Your Health. Our Mission.

Pueblo Community Health Center, Inc.
110 East Routt Avenue
Pueblo, CO 81004
719-543-8711 (Phone) 719-543-0171 (Fax)

Authorization for the Use or Disclose of Protected Health Information

Patient Name: _____ DOB: _____ Medical Record # _____

Address: _____

Telephone # _____ E-mail Address _____

I, _____ , authorize Pueblo Community Health Center, Inc., to Release ☐ Receive ☑
Patient or Legal Representative

medical records

To ☐ From ☑

Name: _____ Phone: _____

Address: _____

Only the following specific information: Other _____ Date(s) of Service: _____

Or:

☐ Entire Medical Record and for specified date(s) of service: From; _____ To: _____

☐ Behavioral Health and for specified dates(s) of service: From: _____ To: _____

☐ Dental and for specified dates(s) of service: From: _____ To: _____

Information to be released by: Paper ☐ Electronic ☐

I understand that information disclosed pursuant to this authorization may include information relating to the following, **unless specifically restricted below:**

- Psychological/psychiatric conditions
- HIV/AIDS diagnosis and/or testing
- Drug and/or alcohol abuse diagnosis and/or treatment
- Sexually transmitted disease(s) diagnosis and/or testing
- Genetic Testing

List any restrictions: _____

The purpose of the disclosure is: _____

Re-disclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the Medical Records Department, at the above listed physician/health care provider's office, with a written revocation.

Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Expiration Date: This authorization is in effect for ninety (90) days (unless I provide a written revocation at an earlier date)

Signature of Patient or Legal Representative(s): _____ **Date:** _____

Printed Name(s): _____ Relationship to Patient: _____
(if signed by other than patient)

Staff Initials_____