**Patient Registration Information Forms**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT’S NAME (PLEASE INCLUDE NAME SUFFIX IF APPLICABLE)** | | | | | | | | | | | | | | | | | | | |
| LAST | | | FIRST | | | | | | | MIDDLE | | MAIDEN OR SUFFIX | | | | | | | |
| ADDRESS | | | | | | | | | | | | | | | | | | | |
| PO BOX/STREET | | | ZIP CODE | | | | CITY | | | | | | | | STATE | | | | |
| HOME PHONE NUMBER | CELL PHONE NUMBER | | | | | | | | SOCIAL SECURITY NUMBER | | | | | | | | SEX (CIRCLE ONE)  MALE FEMALE | | |
| EMAIL ADDRESS: | | | | | | | | | RACE (CIRCLE ONE) WHITE BLACK/AFRICAN AMERICAN  AMERICAN INDIAN ALASKA NATIVE  ASIAN PACIFIC ISLANDER UNREPORTED/REFUSED | | | | | | | | | | |
| MARITAL STATUS (CIRCLE ONE)  SINGLE MARRIED WIDOWED  DIVORCED SEPARATED | | BIRTHDATE | | | | | | | ETHNICITY (CIRCLE ONE) HISPANIC    LATINO OTHER UNREPORTED/REFUSED | | | | | | | | | | |
| |  | | --- | | VETERAN (CIRCLE ONE) YES NO |   ALLERGIES (PLEASE CIRCLE ONE): YES NO  **IF YES, PLEASE LIST**: | | | | | | | | | | | | | | | | | | | |
| **EMERGENCY CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | | |
| CONTACT NAME | | | | RELATIONSHIP | | | | HOME PHONE NUMBER | | | | | | CELL PHONE NUMBER | | | | | |
| SECOND CONTACT NAME | | | | RELATIONSHIP | | | | HOME PHONE NUMBER | | | | | | CELL PHONE NUMBER | | | | | |
| RESPONSIBLE PARTY (Required if patient is under age 18) | | | | | | | | DATE OF Birth | | | | | | SOCIAL SECURITY NUMBER | | | | | |
| **NOTIFICATION AUTHORIZATION**  This is to obtain your preference for notification of lab and x-ray results or regarding information about medications (please check in the appropriate area)  ( )1. Try to contact me by telephone, but if you do not reach me directly, **do not** leave any type of message on the answering  machine or with person answering the telephone  ( )2. If you do not reach me directly, by telephone, HAHC may leave actual results on answering machine or with person answering the telephone  ( )3. I would like to make other arrangement (please specify):    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **PATIENT’S EMPLOYMENT INFORMATION** | | | | | | | | | | | | | | | | | | | |
| OCCUPATION | | | | | | | | EMPLOYER’S NAME | | | | | | | | | | | |
| EMPLOYER’S ADDRESS | | | | | | | | | | | | | | | | | | | |
| STREET | | | | | ZIP CODE | | | CITY | | | | | | | | | | STATE | |
| EMPLOYER’S PHONE NUMBER | | | | | | | | | | | | | | | | | | | |
| **GUARANTOR/PRIMARY INSURANCE CARDHOLDER’S INFORMATION** | | | | | | | | | | | | | | | | | | | |
| LAST NAME | | | | FIRST NAME | | | | | | | MIDDLE | | | | | BIRTHDATE | | | |
| SOCIAL SECURITY NUMBER | | OCCUPATION | | | | | | | | | | | SEX (CIRCLE ONE)  MALE FEMALE | | | | | | |
| GUARANTOR’S EMPLOYER NAME | | | | | | | | EMPLOYERS’ PHONE NUMBER | | | | | | | | | | | |
| GUARANTOR’S EMPLOYER ADDRESS | | | | | | | | | | | | | | | | | | | |
| PO BOX/STREET | | | | | | ZIP CODE | | CITY | | | | | | | | | | | STATE |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MEDICAL INSURANCE INFORMATION** | | | | | | |
| PRIMARY INSURANCE NAME | POLICY NUMBER | | | GROUP NUMBER | INSURANCE PHONE NUMBER | |
| INSURANCE STREET ADDRESS | | ZIP CODE | CITY | | | STATE |
| SECONDARY INSURANCE NAME | POLICY NUMBER | | | GROUP NUMBER | INSURANCE PHONE NUMBER | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **DENTAL INSURANCE INFORMATION (if applicable)** | | | | | | |
| PRIMARY INSURANCE NAME | POLICY NUMBER | | | GROUP NUMBER | INSURANCE PHONE NUMBER | |
| INSURANCE STREET ADDRESS | | ZIP CODE | CITY | | | STATE |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PRESCRIPTION INSURANCE INFORMATION (if applicable)** | | | | | | |
| PRIMARY INSURANCE NAME | POLICY NUMBER | | | GROUP NUMBER | INSURANCE PHONE NUMBER | |
| INSURANCE STREET ADDRESS | | ZIP CODE | CITY | | | STATE |
| SECONDARY INSURANCE NAME | POLICY NUMBER | | | GROUP NUMBER | INSURANCE PHONE NUMBER | |

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT’S PHARMACY INFORMATION** | | | |
| PHARMACY NAME | | PHARMACY TELEPHONE NUMBER | |
| ADDRESS: | ZIP CODE | CITY | STATE |
| **This information is required as HAHC submits prescriptions electronically.** | | | |

|  |
| --- |
| **Income Verification** |
| HAHC offers a sliding fee scale based on income and family size to all patients. To see if you will qualify please complete the following. **Proof of income will be required before receiving the sliding fee discount.** |
| Your Family Size and Income – first find and circle your family size, then go across that line, find and check the annual income range for your family. |
| Family size 1 person: € $0 - $11,670 € $11,671 - $23,340 € $23,341 & above |
| Family size 2 people: € $0 - $15,730 € $15,731 - $31,460 € $31,460 & above |
| Family size 3 people: € $0 - $19,790 € $19,791 - $39,580 € $39,581 & above |
| Family size 4 people: € $0 - $23,850 € $23,851 - $47,700 € $47,701 & above |
| Family size 5 people: € $0 - $27,910 € $27,911 - $55,820 € $55,821 & above |
| Family size 6 people: € $0 - $31,970 € $31,971 - $63,940 € $63,941 & above |
| Family size 7 people: € $0 - $36,030 € $36,031 - $72,060 € $72,061 & above |
| Family size 8 people: € $0 - $40,090 € $40,091 - $80,180 € $80,180 & above |
| For each additional person over 8 family members add: $4,060 |

**How did you hear about the health center (please circle):**

* Friend or Family Member
* Newspaper or advertising
* Insurance company
* Doctor referral
* Other (please list)

|  |
| --- |
| **CONSENT, ASSIGNMENT AND RELEASE** |
| 1. I give permission for Hyndman Area Health Center, Inc. to give me treatment.  (patient name)  2. I request that payment of authorized benefits is made on my behalf to the Hyndman Area Health Center, Inc. for any services rendered to me by their medical and/or dental providers. I authorize Hyndman Area Health Center, Inc. to release medical and/or dental information to my current insurance company and its agents to determine these benefits or the benefits payable for related services.  I understand that:   * Hyndman Area Health Center will have to send my health information to my insurance company. * I must pay my share of the costs when I receive my treatment. * I must pay for the cost of these services if my insurance does not pay after 90 days or if I do not have insurance.   3. I understand:   * I have the right to refuse any procedure or treatment. * I have the right to discuss all medical treatments with my provider. * I may request a copy of HAHC’s Notice of Privacy Practice at any time.   4. I have read the consent to treat or have had this consent read to me.  5. I have been able to ask questions and my questions were fully answered.    Patient’s Signature Date    Parent or Guardian Signature Date  (for children under 18)    Print Name |

Updated April 2014

Hyndman Area Health Center

144 Fifth Avenue

PO Box 706

Hyndman, PA 15545

814-842-3206 Fax: 814-842-3746

**Initial Health History**

Name

First Middle Last

Today's Date Date of Birth

Address

Telephone Number home ( )

cell ( )

work ( )

**GENERAL HEALTH**

**Why did you make this appointment**? (Check all that apply.)

regular checkup

first appointment to start care with a new doctor

switching doctors: from whom:

have a specific health problem: if so, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In general, what do you consider to be your **main health problem**(s)? (Check all that apply.)

heart problems  diabetes  thyroid problems

stomach problems  depression/emotional problems

ear, nose, or throat problems  joint problems

high blood pressure  breathing problems

Other(s) – please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you **describe your health**?

Excellent  Very Good  Good  Fair  Poor

Are you taking any **prescription medicines**?

Yes. Please list your medicines below OR  I brought my pill bottles or a list.

No, I do not take any prescription medicines.

|  |  |  |
| --- | --- | --- |
| **Name of medicine** | **Amount (mg/mcg/IU)** | **How many pills or doses do you take at** |
|  |  | morning noon dinner bed |
|  |  | morning noon dinner bed |
|  |  | morning noon dinner bed |
|  |  | morning noon dinner bed |
|  |  | morning noon dinner bed |
|  |  | morning noon dinner bed |
|  |  | morning noon dinner bed |

**Please use the back of this form if you have more prescription medicines**

What **over-the-counter medicines** do you take regularly?

Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, and Aspirin)

Vitamins

Antacid (for example: Tums, Prilosec)

Herbal medicine (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

None - I do not take any over-the-counter medicines regularly.

Have you ever had any **allergic reaction (bad effects)** to a medicine or a shot?

Yes. (Please write the name of the medicine and the effect you had.)

No, I am not allergic to any medicines.

|  |  |
| --- | --- |
| **Medicine I am allergic to** | **What happens when I take that medicine** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Do you get an **allergic reaction (bad effect)** from any of the following? (Check all that apply)

latex (rubber gloves)

grass or pollen

eggs

shellfish

Other (please describe)

No - I have no allergies that I know of.

Have you ever been a **patient** **in a hospital** overnight?

Yes. (If yes, explain EACH reason and when.)

No, I have never been a patient in a hospital.

|  |  |
| --- | --- |
| **I was in the hospital because:** | **When** |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **SURGICAL HISTORY** |

Have you ever had a surgery?  Yes (if yes, please list below with dates)  No

|  |  |
| --- | --- |
| **Surgery** | **Year** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Have you ever had a  colonoscopy  sigmoidoscopy?

When

Was it abnormal?  Yes No

Have you ever received a **blood transfusion?**  Yes No

When

Do you have **advanced directives** in place (DNR, living will, etc.)?  Yes  No

What do you have in place? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR WOMEN ONLY**

Age at start of periods: \_\_\_\_\_\_ First day of last menstrual period: \_\_\_\_\_\_\_\_\_\_ Age at end of periods:\_\_\_\_\_\_

Do you have problems with your periods or birth control?  No  Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If post menopause or over age 50, do you take:**

Calcium  Yes  No Estrogen  Yes  No Progesterone  Yes  No

Have you ever been **pregnant**?  Yes No

How many times?

How many children have you given birth to?

Have you had a **Pap smear**?  Yes No

Date of last one

Have you ever had a **Pap smear that was not normal**?  Yes No

Have you had a **mammogram?**   Yes No

Date of last one

Have you had a **DEXA scan**/bone density test?  Yes No

Date of last one\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **MEN ONLY** |

Have you had a PSA blood test?  Yes No

Was it abnormal?  Yes No

Date of last one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a digital rectal exam?  Yes No

Was it abnormal?  Yes No

Date of last one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATIONS**

When was your last **Tetanus shot**? Year never  don’t know

When was your last **Pneumonia shot**? Year never  don’t know

When was your last **Flu shot**? Year never  don’t know

Other shots you have had (please check all that apply)

Hepatitis A series  MMR

Hepatitis B series  Meningitis

**SOCIAL HISTORY**

What language do you prefer to speak? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle the **highest grade** you finished in school?

1 2 3 4 5 6 7 8 9 10 11 12 GED 1 2 3 1 2 3 4+

Grade School High School Vocational School College

**What do you do during the day**?

Work full-time  Work part-time  Attend school

Caregiver  Stay home  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you **ever smoked cigarettes, cigars, used snuff, or chewed tobacco**?

No Yes

a. When did you start?

b. How much per week?

c. Have you quit?  No  Yes, when \_

d. Do you want to quit  No Yes  Already Quit

Do you drink **alcohol**?

No  Yes

a. Have you ever felt you ought to cut down on your drinking?  Yes No

b. Have people ever annoyed you by criticizing your drinking?  Yes No

c. Have you ever felt bad or guilty about your drinking?  Yes No

d. Have you ever had a drink first thing in the morning?  Yes No

Do you or any household members use **illegal drugs**:  No  If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of drugs do you or your household members use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or any household members have an addiction to prescription medications?

No  if yes, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of prescription medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine use:  None  Coffee/Soda/Tea \_\_\_\_\_\_ cups/day

Do you exercise?  if no, why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  yes, I exercise

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What kind of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you  Single  Married  Partnered  Divorced or Separated  Widowed

Spouse/Partner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in your house?

Are you sexually active?  Yes  No  Not currently

Do you have **sex** with  men  women  both  neither

Birth control method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past year, have you been **emotionally or physically abused** by your partner or someone important to you?  Yes No

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **FAMILY HISTORY:** Please list family members (mother, father, sister, brother, aunt/uncle, grandparents) |

|  |  |
| --- | --- |
| Alcoholism | High cholesterol |
| Cancer (type) | High blood pressure |
| Heart disease | Stroke |
| Depression | Bleeding disorder |
| Bipolar Disorder | Schizophrenia |
| Genetic Disorder | Asthma/COPD |
| Diabetes | Crohn’s Disease |
| Other (s): | |

|  |
| --- |
| **PERSONAL MEDICAL HISTORY:** Have you had any of the following medical conditions? (Mark all that apply) |

Anemia  Asthma  Diabetes (sugar)  Irritable Bowels

Heart Trouble  Hemorrhoids  Cancer

Hepatitis  Tuberculosis  Liver Trouble

Pneumonia  Rheumatic fever  Ulcers

Stroke  High Blood Pressure  Anxiety

Skin problems  Depression/Bipolar Disorder  Epilepsy

Sexually Transmitted Infections  Crohn’s Disease/Colitis  COPD

|  |
| --- |
| **REVIEW OF SYSTEMS:** Please check any CURRENT symptoms you have |

**CONSTITUTIONAL** **RESPIRATORY**  **HEMATOLOGY/LYMPH**

Weight Loss /Gain  Cough/Wheezing  Easy Bruising

Fatigue  Coughing up blood  Blood Gums Bleed Easily

Fever/Chills  Enlarged glands

**EYES MUSCULOSKELETAL GASTROINTESTINAL**

Glasses/Contacts  Joint Pain/Swelling  Acid Reflux

Eye Pain  Recent Back Pain  Nausea/Vomiting/Diarrhea/ Constipation

Double Vision  Abdominal Pain

Cataracts  Blood or change in bowel movements

**EAR,NOSE,THROAT**  **SKIN NEUROLOGICAL**

Difficulty Hearing/Ringing in ears  Rash/Sores  Headaches

Hay fever/Allergies/Congestion  New or change in mole  Memory loss

Warts  Fainting/Falling

**GENITOURINARY: HEART PSYCHIATRIC/EMOTIONAL**

Burning/Frequency  Murmur  Anxiety/Stress

Blood in Urine  Chest Pain  Sleep problems

Nighttime Urination  Palpitations

Abnormal Discharge  Shortness of Breath with Activity

Leaking urine/weak urine stream

Unusual vaginal bleeding

**ENDOCRINE BREAST**

Cold/Heat Sensitive  Breast Lump

Increased Thirst/Appetite  Nipple Discharge

Signature of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised: 2012 March

Hyndman Area Health Center

144 Fifth Avenue

PO Box 706

Hyndman, PA 15545

814-842-3206 Fax: 814-842-3746

|  |  |  |
| --- | --- | --- |
| Date: | | |
| Patient Name: | | Date of Birth: |
| **MESSAGE AUTHORIZATION** | | |
| If we need to contact your, may we leave a message at your: | | |
| Home Telephone Number Yes \_\_\_\_ No\_\_\_\_ | | ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cell Phone Number Yes \_\_\_\_ No\_\_\_\_ | | ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employer Phone Number Yes \_\_\_\_ No\_\_\_\_ | | ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **REQUEST FOR SPECIAL PERMISSION** | | |
| I understand that my physician may use or disclose my protected health information (PHI) for the purpose of treatment, payment and health care operations. My physician may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend.  I hereby permit HAHC to disclose this information to the following people: | | |
| **Persons Name** | **Relationship to Patient** | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
| **Comments or special instructions**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Signature of patient or his/her authorized representative Date | | |

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# Patient Bill of Rights

* To receive quality medical and dental care regardless of your age, sex, religion, national origin, sexual preference, disability, health status or ability to pay.
* To be treated with respect by Hyndman Area Health Center.
* To information contained in your medical record. You also have the right to participate in decisions involving your health care.
* To personal privacy. Any discussion, consultation, examination and/or treatment regarding your care will be done discreetly.
* To confidentiality of your medical record and other information related to your medical condition.
* To be seen in a safe and clean environment.
* To have special needs met, such as an interpreter to help with communication.
* To appoint a person to make health care decisions on your behalf in the event you lose the ability to do so.
* To make advance directives regarding your medical care and have them honored.
* To file a complaint about your care without fear of penalty, to have your complaint reviewed, and when possible, resolved.

### Your responsibilities as a Patient are:

* To provide, to the best of your knowledge, complete information about your symptoms, past illnesses, medications and other matters relating to your plan of care.
* To schedule and keep doctor/dentist appointments, or call to cancel your appointment if you cannot be there.
* To notify the Network of any changes in address, family members or insurance coverage (provide a current copy of insurance card).
* To ask questions when you do not understand explanations about your care or services.
* To be responsible for your actions if you refuse treatment or do not follow your physician’s/dentist’s instructions.
* To follow the organization’s policies.
* To be courteous and considerate of Hyndman Area Health Center personnel and other patients.

***October 2013***

Hyndman Area Health Center

144 Fifth Avenue

PO Box 706

Hyndman, PA 15545

814-842-3206 Fax: 814-842-3746

What is a Federally Qualified Health Center?

* **A Federally Qualified Health Center is a partnership between patients, the government, and communities that work together to best meet health care needs*.***
  + They constitute a vital safety net in the nation’s health delivery system that works to meet escalating health needs, reduce health disparities, and bring doctors and health services into medically underserved areas. Today this growing nationwide network of over 1,200 Health Centers serve more than 18 million people at 7,000 urban and rural communities in all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.
* **Federally Qualified Health Centers fill critical gaps in health care by serving the working poor, the uninsured, and the medically underserved as well as many other high-risk and vulnerable populations.**
  + Federally Qualified Health Centers serve as family medicine providers to one of every 7 uninsured persons, one of every 6 low-income Americans, and one of every 7 rural Americans who otherwise would lack access to health care. In addition, health centers and their innovative programs in primary care and prevention reach out to more than 600,000 homeless persons and 700,000 migrant and seasonal farm workers.
* **Federally Qualified Health Centers are built by community initiatives. Federal grants provide money which empowers communities to recruit providers and other health professionals. These federal grants also help communities to build their own points of entry into the nation’s health care delivery system.**
  + Federal grants constitute an average 25 percent of a Health Center’s budget. The remainder is leveraged from state and local governments, Medicare and Medicaid, private contributions, private insurance, and patient fees. Medicaid is the largest source of revenue averaging 35 percent of total revenue.
* **Federally Qualified Health Centers make a large contribution to communities by keeping the doors of health care open to all who seek their care.**
  + It is estimated that Health Centers save the health system and American taxpayers seven billion dollars per year by keeping people healthy and out of costly hospital and emergency room visits. Patients are charged on a sliding fee scale to ensure that income or lack of insurance is not a barrier to care. The Health Center approach is aimed at lowering the costs of disease through accessible and affordable primary care and prevention.
* **Federally Qualified Health Centers are community driven and patient centered.**
  + Health Centers tailor services to fit the special needs and priorities of their communities. Serving high-risk and vulnerable populations, Centers integrate the delivery of primary care with patient outreach, education, translation, and support services to make health care responsive and cost effective. Their innovative programs are designed to ensure that patients have access not only to medical treatment but a continuum of coordinated care and vital support services that can lead to positive health outcomes and healthier behaviors and lifestyles.
* ***Federally Qualified Health Centers enable communities and their residents to make health and disease prevention a priority.***
  + Health Centers interact with schools, businesses, community organizations, foundations, and state and local governments. They bring communities together in the effort to develop locally responsive strategies that can effectively meet special needs and address costly and devastating health problems which include substance abuse, domestic violence, infant mortality, homelessness, and AIDS. They are strong partnerships that join the public and private sectors to support community initiatives for better health.
* **Federally Qualified Health Centers hold high standards of accountability for patient care and effective use of public and private funds.**
  + Governed by volunteer consumer boards comprised of patients and civic leaders, Health Centers ensure that care is patient-centered and responsive to diverse cultures and needs within the communities served.
* **Federally Qualified Health Centers allow for cost savings within their communities and the nation.**
  + Health Centers significantly increase the use of preventive health services such as immunizations, Pap smears, mammograms, and glaucoma screenings. In addition, Health Centers save the Medicaid program at least 30 percent in annual spending for its beneficiaries due to reduced specialty care referrals and fewer hospital admissions. It is estimated that Health Centers save almost 3 billion dollars annually in combined federal and state Medicaid expenditures.
* **Federally Qualified Health Centers are vital mainstays in America’s communities.**
  + Health Centers contribute to the health and well being of their communities by keeping children healthy and helping adults remain productive and on the job. They recruit and train health professionals for service in rural and medically underserved areas. Likewise, Health Centers provide jobs for 70,000 individuals, most of who are community residents, and engage citizen participation and involvement. Moreover, Health Centers are engines of economic development in their communities spending nearly 6 billion dollars a year, with combined payrolls exceeding 4 billion dollars and generating more than 20 billion dollars in economic output for low-income communities across the nation.

***America’s Federally Qualified Health Centers have produced a model of health care that has demonstrated that this nation can meet compelling health needs while decreasing health care costs. The Health Center legacy proudly shows the value and vast potential of a community-based health system that is lifting the barriers to health care, safeguarding health, revitalizing communities, and keeping people healthy at cost savings for the nation.***