Highway 54:(P)580-338-0072(F): 580-338-0077
Pathways:(P) 580-338-4638 (F): 580-338-4642

Patient Information Form

Please Present **PHOTO ID**
and **INSURANCE CARD** if available.

Proof of income must be presented to qualify for our sliding scale.

FULL LEGAL NAME:

SOCIAL SECURITY #: **DATE OF BIRTH:** **AGE:**

MAILING ADDRESS:

CITY: **STATE:** **ZIP:**

PHONE HOME: **WORK:** **CELL:**

EMAIL ADDRESS: **PREFERRED METHOD OF CONTACT:** O **EMAIL** O **PHONE**

RACE

(Please Check All That Apply)

- O White/Caucasian
- O Black/African American
- O Asian
- O American Indian/Alaska
- O Native Hawaiian
- O Other Pacific Islander
- O Hispanic/Latino Origin
- O Unreported/Refuse to Report

SEXUAL ORIENTATION

- O Lesbian or Gay
- O Straight
- O Bisexual
- O Something Else
- O Don't Know
- O Choose Not to Disclose

GENDER IDENTITY

- O Male
- O Female
- O Transgender Male/Female to Male
- O Transgender Female/Male to Female
- O Choose Not to Disclose

MARITAL STATUS

- O Single
- O Married
- O Widowed
- O Separated

Language Best Served: ______________________________

Interpreter Needed/Required: Yes O No O

PLEASE CHECK if applicable:

O Veteran O Seasonal Worker O Migrant O Homeless O In Public Housing

Pharmacy: ______________________ **City:** ______________ **State:** ______________

Known Medical Allergies: ____

EMERGENCY CONTACT INFORMATION

Name: **Phone:** **Relationship:**

INSURANCE INFORMATION		**RESPONSIBLE PARTY IF NOT SELF**			**RELATIONSHIP**
PRIMARY INSURANCE:		**NAME:**			O Spouse O Parent O Guardian O Other (Specify)
INSURED'S NAME:		**DOB:**	**SSN:**		
DOB:	**SSN:**	**ADDRESS:**			
ADDRESS:		**CITY, STATE, ZIP:**			
CITY, STATE, ZIP:		**PHONE – WORK:**	**HOME:**	**CELL:**	

Print Full Name: ______________________________ DOB: ____________ Today's Date: ____________

PATIENT HEALTH QUESTIONNAIRE - 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
For office coding	0 +	+	+	

= Total Score: ____________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

FOR OFFICE USE ONLY:

PQH-9 Severity: __________

Staff Initials: ____________

Score: ____________

(Please list all members in household)

Number of persons in your household: ________

NAME & DATE OF BIRTH	NAME & DATE OF BIRTH
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

****

SLIDING SCALE FORM

The Panhandle Counseling and Health Center provides sliding fee discounts based on household income and number of dependents.

I understand that Panhandle Counseling and Health Center provides sliding fee discounts based on household income and number of dependents. Verification of household income is needed in order to apply for discounts. Proof of income can be in the form of **your paycheck stubs, social security letter, unemployment letter, food stamp letter or current year income tax return. By filling out this form and signing it, I wish to participate in sliding fee discount program.**

By signing this form, I affirm that all information given is an accurate statement of income at this time of application. I agree to report any changes or circumstances. Income verification is done at least yearly – more often as income or circumstances change.

I understand that a person who obtains or attempts to obtain services to which he is not entitled may be prosecuted under applicable state and Federal law.

Is anyone in your household employed? Yes _______No ______ If yes, list below (including farm, non-farm & self-employment wages)

Name: ____________________________________ Where employed: ____________________________________

Signature of Applicant: _____________________________________ Date: ______________________________

I understand that that Panhandle Counseling and Health Center provides sliding fee discounts based on my household income and number of dependents.

My signature below indicates that I <u>do not</u> want to participate in this program.

SIGNED: ____ DATE: ______________

28114-3

Sliding Fee Scale 2021

Who Can Qualify?

The sliding fee is a formula used to determine the availability of reduced charges to patients who qualify according to the number in the family and the average yearly income of the family, regardless if the patient or family has insurance or not.

HOW TO READ THE SLIDING FEE SCALE

1. Locate the row corresponding to the number of individuals in your family.
2. Move to the right until you find the range containing your average annual income.

For each additional family member over 8 add $4,540. In row A, the patient is asked to pay $15.00 for an office visit. In the other categories the patient is asked to pay the percentage of billed charges.

HOW DO I QUALIFY

1. To qualify for the sliding fee, you must fill out a form. These can be picked up at the clinic.
2. You must provide proof of income by presenting at the least one of the following items:

a. Tax forms from the most recent year.
b. Paycheck stubs for one month, preferably with year-to-date income provided.
c. Office of Public Assistance benefit printout (food stamp benefit history).
d. Fixed income statement; i.e., pension, social security or bank statement showing deposits.

% of Federal Poverty Guidelines	0-100%	101%-150%	151%-175%	176%-180%	181%-200%	Over 200%
Amount Owed	Minimum Charges	20%	40%	60%	80%	Full Charge
Family Size	A	B	C	D	E	F
1	$0 $12,880	$12,881 to $19,320	$19,321 to $22,540	$22,541 to $23,184	$23,185 to $25,760	$25,761 & Above
2	$0 $17,420	$17,421 to $26,130	$26,131 to $30,485	$30,486 to $31,356	$31,357 to $34,840	$34,841 & Above
3	$0 $21,960	$21,961 to $32,940	$32,941 to $38,430	$38,431 to $39,528	$39,529 to $43,920	$43,921 & Above
4	$0 26,500	$26,501 to $39,750	$39,751 to $46,375	$46,376 to $47,700	$47,701 to $53,000	$53,001 & Above
5	$0 $31,040	$31,041 to $46,560	$46,561 to $54,320	$54,321 to $55,872	$55,873 to $62,080	$62,081 & Above
6	$0 $35,580	$35,581 to $53,370	$53,371 to $62,265	$62,266 to $64,044	$64,045 to $71,160	$71,161 & Above
7	$0 $40,120	$40,121 to $60,180	$60,181 to $70,210	$70,211 to $72,216	$72,217 to $80,240	$80,241 & Above
8	$0 $44,660	$44,661 to $66,990	$66,991 to $78,155	$78,156 to $80,388	$80,389 to $89,320	$89,321 & Above

HEALTH CARE PAYMENT AGREEMENT

1. **INSURANCE** – We participate in most insurance plans. However, you must know your insurance benefits are your responsibility. Please contact your insurance company to verify that our physicians are in their network and with any questions you may have regarding your coverage.
2. **CO-PAYMENTS AND DEDUCTIBLES** – Co-payments and deductibles are encouraged at the time of service. This arrangement is part of your contract with your insurance company. Patients unable to pay the balance due in full can make monthly payment arrangements by contacting the PCHC staff.
3. **NON-COVERED SERVICES** – Please be aware that some of the services you receive may not be covered or not considered medically necessary by Medicare or other Insurers. You will be asked to sign for these services and will be responsible for these charges.
4. **PROOF OF INSURANCE** – We must obtain a copy of your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.
5. **CLAIM SUBMISSION** – We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays for your claim. Your insurance benefit is a contract between you and your insurance company.
6. **SLIDING FEE SCALE DISCOUNTS** – As a Federally Qualified Healthcare Center, we may be able to offer you a sliding fee discount based on your household income. Guidelines and applications are available at the front desk. Once your completed application with proof of income is received, it will be reviewed. Once qualified, you will receive a letter indicating the amount of discount offered along with the expiration date.
7. **COLLECTIONS** – If we have not received a payment after 60 days, your account will be put into collection status, and you will receive a letter notifying you that your account is past due. If a payment is not made in 30 days you will receive a final notice requiring a payment to be made in 5 days. If your account continues to go unpaid, your account may be sent to an outside collection agency. Patient accounts will be sent to collections in Pre-Collect which gives the patient 30 days to pay before interest is charged or it is reported on their credit. All accounts that have a mail return may be sent to collections and be placed in Direct Collections.

THE PCHC BOARD OF DIRECTORS HAS APPROVED THIS DOCUMENT.
A copy will be provided to the patient upon signature.

______________________________ ______________________________

Patient Signature **Date**

PATIENT-PROVIDER AGREEMENT

Dear Patient,

Welcome and thank you for choosing Panhandle Counseling and Health Center. We are committed to providing you with the best medical care based on your health needs. Our hope is that we can form a partnership to keep your whole self as healthy as possible, no matter what your current state of health.

Your commitment to our Patient-Centered Medical Home practice will provide you with an expanded type of care. Panhandle Counseling and Health Center will work with you and other health care providers as team to take care of you. You will also have better access through phone and Web visits and secure email.

As your primary care provider, PCHC will:

- **We will listen and learn about you, your family, life situations, preferences, health goals, and other needs that concern you.**
- **We will be pleased to care for your short-term illness, long-term chronic disease and your all-around well-being.**
- **We will help you keep up-to-date on all your vaccines/immunizations and preventative screening tests.**
- **Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them as your health needs change.**
- **An on-call nurse is available for after hours for your urgent needs.**
- **Notify you of test results in a timely manner.**
- **Communicate clearly so that you understand your condition(s) and all of your options. We will also help you to make the best decision for your health.**
- **As part of this partnership we also ask that you provide us with feedback so that we may improve how we serve you.**

PCHC trusts you, to participate with PCHC in your care:

- **Notify us when you have seen other health care providers such as: eye doctors, dentists, chiropractors, and any specialist. With this information we can better serve you with reminders on health screenings.**
- **Agree that all health care providers at PCHC will receive all information related to your health care if needed and that you are a partner in your healthcare needs.**
- **Keep your scheduled appointments; make follow up appointments at each visit as directed.**
- **If you are unable to keep appointments, including labs please cancel as soon as possible, but reschedule so that you can continue to follow the plan of care that has been developed by you and agreed to by your medical team.**
- **Bring all medications, remedies, any supplements you are taking, and any new concerns. Let us know if you don’t understand something.**
- **Medication refills require 24-48-hour notice.**
- **Contact us after hours, only if your issue cannot wait until the next business day. If it is an Emergency-Call 911 immediately.**
- **When possible, contact us before going to the emergency room**
- **Learn about your health insurance coverage and benefits. Pay your share of any fees.**
- **Give us feedback to help PCHC improve our care for you.**

Please fill in below the name of the provider you have chosen to be your Primary Care Provider for PCH.

____ is the provider I have chosen and I agree to partner with this provider for my health care needs.

Patient/Guardian Signature	**Printed Patient/Guardian Name**	**Date**

Provider/Designated Signee	**Date**

28114-6

PATIENT AGREEMENTS AND ACKNOWLEDGEMENT

AUTHORIZATION FOR MEDICAL TREATMENT

Panhandle Counseling and Health Center and its personnel are hereby authorized to administer any medical, dental, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I represent to Panhandle Counseling and Health Center that I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

ELECTRONIC HEALTH INFORMATION NETWORKS

Until now, providers and health plans have exchanged information about you for purposes of treatment, payment, and health care operations directly by hand-delivery, telephone, mail, facsimile, or email. This process is time consuming and expensive, may not be secure, and often is unreliable. Electronic health information networks change this process. New technology allows a provider or a health plan to submit a single request through a health information network to obtain electronic records for a specific patient from other network participants. Your electronic medical record will be included in the network and accessed by other network participants who have a relationship to you, unless you affirmatively choose not to participate by submitting and Opt-Out Request to the network. By opting out, your information would be blocked from being seen by network participants.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance or medical benefits for Panhandle Counseling and Health Center charges otherwise payable to me are to be made payable to Panhandle Counseling and Health Center. Any payment received for health services may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

PRECERTIFICATION

I understand that Panhandle Counseling and Health Center will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

Panhandle Counseling and Health Center will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of the Notice of Privacy Practices and this Patient Agreement and Acknowledgement. I further certify that I am the patient or duly authorized by the patient to accept the terms of the Patient Agreement and Acknowledgement. A photocopy of this document has the same effect has an original.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by Panhandle Counseling and Health Center and are accessible to Panhandle Counseling and Health Center personnel as needed to perform their respective job duties. Panhandle Counseling and Health Center personnel in attendance may use and disclose medical information for operational purposes and to any other physician or health care provider involved in my continuum of care. Safeguards are in place to discourage improper access to my protected health information. Panhandle Counseling and Health Center and its personnel are authorized to disclose all or part of my medical record to any insurance carrier or health plan, workers compensation carrier, or self-insured employer group liable for any part of Panhandle Counseling and Health Center's charges and to any health care provider who is or may become involved with my care.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

A complete description of how your medical information will be used and disclosed by PANHANDLE COUNSELING AND HEALTH CENTER is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement. A copy is available to you upon registration and is posted at PANHANDLE COUNSELING AND HEALTH CENTER.

By signing this agreement, I acknowledge receipt of Panhandle Counseling and Health Center's Notice of Privacy Practices and authorize the use and disclosure of my medical information as described in the Notice of Privacy Practices.

____________________	____________________	____________________	____________________
Patient or Responsible Party	**Relationship**	**Date Signed**	**Witness**

Basis for refusal, if refused: ____

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Completion of this form is optional

Patients Name: ________________________________ **Date of Birth:** ____________________

Patients mailing address: __________________ **City:** _____________ **State:** _____ **Zip:** __________

Home Phone: _________________ **Work Phone:** _________________ **Cell Phone:** ________________

I give permission to Panhandle Counseling and Health Center to VERBALLY discuss the following medical and billing information about me (Check all boxes that apply):

_____ Appointment information.

_____ Medical information, including my symptoms, diagnosis, medications and treatment plan.

_____ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan.

_____ Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan.

_____ Lab/ test

_____ Billing and payment information

_____ Other (describe): ____

Panhandle Counseling and Health Center has my permission to discuss the above information with:

1. Name: ____
Street Address: ____
City, State, Zip: ____
Home #: ________________________ Work #: ____________________

2. Name: ____
Street Address: ____
City, State, Zip: ____
Home #: ________________________ Work #: ____________________

Date: _________________________

I understand that I have the right to revoke my permission at any time except where Panhandle Counseling Health Center has already made disclosures in reliance upon this request. I understand that I must notify Panhandle Counseling and Health Center in writing if I want to revoke my permission.

Signature of Patient/ Authorized Representative X ____
If authorized representative, please sign and attach copies of supporting legal documentation.

Reason patient is unable to sign: ____

ATTESTATION REGARDING PROOF OF INCOME

I,____attest that, to the best of my knowledge and my belief, the following information provided in this declaration is true and correct. I understand that PCHC may request additional information to substantiate the statements made in this declaration and/or reevaluate my situation in thirty days.

Household Size ____________________ **Household Income** ____________________

I understand that knowingly providing false information to PCHC regarding my financial situation will result in becoming responsible for the full amount of the charges incurred at this clinic.

____
Patient’s Signature

____
Attester’s Signature

____
Date Signed