



Leading you to better health!

## PATIENT DEMOGRAPHIC FORM

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Marital Status: • S • M • D • W

Gender at Birth: • Male • Female Gender Identity: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Sexual Orientation: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Language Spoken: \_\_\_\_\_ Translator Needed? • Yes • No

**Message Preferences:** • Voice **or** • Text **Type:** • Extended **or** • Brief **Time of Day:** • Morning • Afternoon • Night

### [HEALOW App](#)

Our patient portal lets you access your health records including labs, request medication refills, and communicate with your Provider.

**Would you like to sign up?** • Yes • No **Email:** \_\_\_\_\_

### **Responsible Party- if patient is under the age of 18**

**(It is the person who is signing the HIPAA/PHI Consent to Treat form):** • Same Address as Patient

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Legal Guardian: • YES • NO

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Message Preferences: • Voice **or** • Text

### **Emergency Contact Information:** • Same as Responsible Party

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Relationships \_\_\_\_\_ Cell Phone \_\_\_\_\_ Message Preferences: • Voice **or** • Text

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Race: (Check all that apply):** • White • Native American Indian (or) Alaska Native • Other Pacific Islander • Native Hawaiian • Black (or) African American • Asian • Asian Indian • Chinese • Filipino • Guamanian or Chamorro • Japanese • Korean • Samoan • Vietnamese • Other • Decline to Specify

**Ethnicity:** • Not Hispanic • Hispanic • Mexican • Mexican American • Puerto Rican • Chicano • Cuban • Declined to Specify

**Do you have an Advanced Directive or Living Will?** • Yes • No

**Pharmacy:** Name: \_\_\_\_\_ Address: \_\_\_\_\_ City \_\_\_\_\_

**STAFF USE ONLY BELOW**

**STAFF MEMBER RESPONSIBLE FOR ENTRY:**

**SCANNED: PIC ID • PRIMARY INS CARD • SECONDARY INS CARD (IF APPLICABLE) • Web/Messenger**

**Configuration •**



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## HIPAA/PHI Consent to Treat

I consent to exam and treatment as necessary, including acquisition of medical, behavioral health, and pharmaceutical history. I hereby authorize WindRose Health Network to release any information regarding services rendered by WindRose Health Network to my health insurance company and in the case of Medicare and the Health Care Financing and its agents; and allow a photocopy of my signature to be used to file insurance, including Medicare, when applicable. I request that payment, including Medicare-authorized benefits, be made either to me or on my behalf to WindRose Health Network. I authorize and direct my insurer to issue payment for authorized benefits due for the services rendered by WindRose Health Network to be made directly to Windrose Health Network. Regardless of my health insurance benefits, if any, I understand I am financially responsible for the fees for services and any cost incurred.

With my consent, WindRose Health Network (WHN) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the WHN Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. WHN reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to WHN Privacy Officer at 1052 Greenwood Springs Blvd, Suite H, Greenwood, IN 46143.

With my consent, WHN may call my home, cell or designated location and leave a message on voice mail or in person about any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent, WHN may mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

Authorization is hereby granted to receive and to release all medical record information of treatment for physical and/or emotional illness, including pharmacy, treatment of alcohol or drug abuse to another health care provider, including faxing this information upon my transfer for further care. I have read and fully understand the above consent and am voluntarily signing it.

☐ I understand that by checking this box I am declining to allow Windrose Health Network to share my Health Information with other entities for the purposes of coordination of my care unless by my specific request in writing.

I have the right to request that WHN restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

***With my consent, WHN may discuss my health and/or financial status with the individuals I have listed below. \*\*Please list these individuals below\*\****

|    | <b><i>Name</i></b> | <b><i>Phone Number</i></b> | <b><i>Relationship</i></b> |
|----|--------------------|----------------------------|----------------------------|
| 1. | _____              | _____                      | _____                      |
| 2. | _____              | _____                      | _____                      |
| 3. | _____              | _____                      | _____                      |

\_\_\_\_\_  
PATIENT'S NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME