WindRose Health Network

"... leading you to better health"

PATIENT DEMOGRAPHIC FORM

Last Name_____ **First Name** _____**MI**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Cell Phone**: _____ **Language Spoken**: _____

Would you like electronic access to your health information through My Healthlink? ☐ YES ☐ NO

Email: _____ **Date of Birth**_____ **Gender**: ☐ Male ☐ Female ☐ Transgender

Marital Status: S M D W **Social Security #** _____

For Children: Mother's Name _____ Father's Name _____

Guardian's Name _____

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_____

Home Phone _____ Cell Phone_____

Emergency Contact Information: ☐ Same as Responsible Party

Last Name _____ First Name_____ MI _____

Relationship _____ Cell/Home Phone _____ Work Phone_____

Address _____ City _____ State _____Zip _____

Income: Household Income $_____ ☐ Yearly ☐ Monthly ☐ Weekly Number in Household _____

I would like to apply for the Sliding Fee Scale at WHN? ☐ Yes ☐ No

Does patient have an Advanced Directive or Living Will? ☐ Yes ☐ No

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

Do you have hearing issues that require assistance from our staff? ☐ Yes ☐ No

Do you have vision issues that require assistance from our staff? ☐ Yes ☐ No

Ethnicity: ☐ non-Hispanic ☐ Hispanic ☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Chicano ☐ Cuban ☐ Declined to Specify

Check any that apply: ☐ Veteran ☐ Migrant ☐ Seasonal Worker ☐ Public Housing ☐ Homeless

Communication Preference: Phone ☐ Text ☐ **Extended or Brief Message:** Extended ☐ Brief ☐

Communication Time Preference: ☐ Morning ☐ Afternoon ☐ Night

Pharmacy: Name: _____ Address: _____City _____

STAFF USE ONLY BELOW

STAFF MEMBER RESPONSIBLE FOR ENTRY: _____ **SCANNED: PIC ID ☐ PRIMARY INS CARD ☐ SECONDARY INS CARD (IF APPLICABLE) ☐ Messenger Configuration ☐ Web-Enable Field Marked ☐**

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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 me 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, the 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, the 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 and I 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 the 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**

	Name	***Phone Number***	***Relationship***
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

_____ _____

PATIENT'S NAME **DATE OF BIRTH**

_____ _____

SIGNATURE OF PATIENT OR LEGAL GURARDIAN **DATE**

_____

PRINTED NAME