ethnē health
a community clinic

Patient Name	Last	First	Middle Initial	Date of Birth

Home Address	House #	Street	Apt #	City	State	Zip

Email Address

Cell Phone:	May we leave a voicemail? (circle one)	Yes | No
	May we send a text message? (circle one)	Yes | No

Gender: Female | Male	**Social Security #:**

Responsible Party: [ ] **Self**
[ ] **Other**: (Name) _____ (Date of Birth) _____ (Relationship to patient)_____

Income/Household Size: Number of people living in your home: _____

Total Monthly Household Income: _____ **OR** Total Yearly Household Income: _____

Insurance Name: _____ **Member ID: _____**

Additional Information

Please circle one option for each question below. We are required to ask these questions, but you may skip any you are not comfortable answering.

Marital Status? Single | Married | Partner | Widowed | Divorced | Legally Separated

Employment Status? Full-time | Part-time | Not Employed | Self-Employed | Retired | Active Military | Student

Employer Name: _____

Race? _____ **Native Country? _____**

Ethnicity? _____

Do you require interpretation services? Yes | No **Native Language? _____**

Sexual Orientation? Straight/Heterosexual | Lesbian or Gay | Bisexual | Other | Don't Know | Choose not to disclose

Gender Identity? Male | Female | Transgender/Female-to-Male | Transgender/Male-to-Female | Other | Choose not to disclose

How did you hear about Ethne Health? _____

Acknowledgements

1) I voluntarily consent to receiving services at Ethne Health. I give permission to all Ethne Health Providers (physicians, physician assistants, nurse practitioners) to use diagnostic and treatment procedures they deem necessary for proper medical management and treatment. I understand that physician's assistants and nurse practitioners are not licensed physicians and may provide medical care only under the supervision and direction of a licensed physician.

2) I assign the payment of claims on my behalf to Ethne Health. I understand that some of the services I receive may not be covered by my third-party payor (Medicare, Medicaid, other insurance), and that I am responsible for paying these amounts.

3) I understand that payment in full is expected before I receive services at Ethne Health. This includes payment of all service fees, copays, and/or coinsurance amounts as discounted based on my fee discount eligibility.

4) I understand that Ethne Health will not write prescriptions for narcotics at a patient's first appointment. I further understand that Ethne Health Providers do not guarantee that they will continue a narcotic prescription.

5) I understand that Ethne Health may discharge me as a patient for cause, or if I do not see a Provider at Ethne Health in a 3 year time period.

I affirm that all information provided in this Patient Information form is true and accurate to the best of my knowledge.

_____ _____ _____

Signature of Patient or Patient's Parent/Guardian Printed Name of Patient or Patient's Parent/Guardian Date

Protection of Health Information (PHI)

Patient Name	Last	First	Middle Initial	Date of Birth

Ethne Health is allowed to share the Patient's Protected Health Information (PHI) with only the people you list below. This PHI includes but is not limited to the Patient's health history, list of medicines, and lab results. These people will also be allowed to pick up the Patient's prescriptions.				May we leave a message on this person's phone?	Should we call this person in case of an emergency?	Can this person give permission to treat the patient (if under 18)?
First Name	Last Name	Phone Number(s)	Relationship to Patient	Yes | No	Yes | No	Yes | No
First Name	Last Name	Phone Number(s)	Relationship to Patient	Yes | No	Yes | No	Yes | No

Note: If the patient under age 18, please include parents/guardians in this list.

By signing below I affirm that:

- *I have been given the chance to review the Notice of Privacy Practices.*
- ***I give permission for Ethne Health to use, to release, and to share the Patient's PHI with necessary third-parties for payment, for treatment, and for general healthcare operations.***
- *I give permission for Ethne Health to share the Patient's PHI and to release the Patient's prescriptions to each of the people listed in the table above.*
- *I understand that I have the right to restrict how Ethne Health shares PHI and I can cancel this permission any time.*
- *I have read, understand, and agree to abide to Ethne Health's No Show Policy*

_____ _____ _____

Signature of Patient or Patient's Parent/Guardian Printed Name of Patient or Patient's Parent/Guardian Date