29 Bruin Drive
Wellsburg, WV 26070
Temporary: (304) 797-7733

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www.changeinc.org

Medical Demographics Form

Patient Name:____
Last Name *First Name* *Middle Initial*

Address:____
 # Street Name *City* *State* *Zip Code*

County:______________ **Home Phone #:** ________________ **Cell Phone #:**______________________

Work Phone #:____________________ **E-Mail:**________________________________

Preferred Method of Contact: □ Home Phone □ Cell Phone □ Work Phone □ Mail □ E-Mail

I would like to sign up to receive appointment reminders via cell phone text message: □ Yes □ No

Marital Status: □ M □ S □ W □ D Maiden Name (if applicable):_______________ **Gender:** □ F □ M

Social Security #:_______/_______/__________ **Employed:** □ **Full-time** □ **Part-time** □ **Student**________

Date of Birth:_____/______/________ **City and State of Birth:**______________________________

Race:________________ **Ethnicity:** □ Non-Hispanic □ Hispanic **Preferred Language:**______________

Agricultural Worker: □ Yes □ No **Veteran:** □Yes □ No

Housing Status: □ **Not Homeless** □ **Homeless Shelter** □ **Public Housing (Not Including Section 8)**
□ **Transitional** □**Other**____

Primary Care Provider:______________________________ **Pharmacy:**________________________

Guardian Name(s) if patient is a minor:____

Relationship to Patient: □ Parent □ Grandparent □ Foster Parent □ Other ________________________

Primary Contact #:__________________________ **Secondary Contact :**______________________

(Mark all that apply to above) □ Emergency Contact □ Primary Care Giver □ Legal Guardian □ Lives With

Name of Emergency Contact: (if different than above)____

Primary Emergency Contact #: (if different than above)______________________________________

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Child Informed Consent Form

I, ________________________________, the parent/guardian of ________________________________,
(Parent/Guardian's Name) (Minor's Name)

grant permission to utilize the medical, dental, and/or behavioral health services offered through the school-based health center.

Initialing each line and/or signing below, you acknowledge all of the following:

________ (Initial)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

In general, any information that is about your health care you receive, or payment for that care, is considered confidential and protected by our practice. We may use your Protected Health Information to carry out treatment, payment, health care operations, and/or other purposes. Our "Notice of Privacy Practices" provides a more complete description of permitted uses and disclosures.

________ (Initial)

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby authorize payment directly to CHANGE, Inc.'s Family Medical Care, for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, co-pays, and deductibles, whether or not paid by Insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions.

________ (Initial)

PATIENT LIABILITY FOR NON-COVERED/INELIGIBLE SERVICES

I understand that the service I will be provided with via my Healthcare Provider or office staff may or may not be covered by my insurance. I understand that it is my responsibility to know my individual insurance plan's covered services, and that CHANGE, Inc.'s Family Medical Care is not responsible to know whether my insurance will pay or require prior-authorization.
If any services I receive at the facility at any time during my course of treatment are deemed non-covered or ineligible or any other reasons unpaid, as well as all efforts are made to obtain payment from my insurance, I understand I am financially responsible for payment of the denied services.

________ (Initial)

ELECTRONIC RECORD TRANSFER

I understand that it may be necessary to transmit my medical records/prescriptions electronically and I authorize to do so. I understand that if I need to transfer my medical records, that I am required to sign a separate Authorization to Release form with the Medical Records department. I absolve CHANGE, Inc.'s Family Medical Care, and its personnel of any liability relating to the transfer of said records.

________ (Initial)

AUTHORIZATION TO TREAT

I hereby authorize any provider employed as part of CHANGE, Inc.'s Family Medical Care Health Centers, to administer such treatment and perform such procedures as may be deemed necessary or advisable in the diagnosis of this patient which may or may not be myself.

________ (Initial)

AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION

I hereby authorize CHANGE, Inc.'s Family Medical Care to exchange health and education records (including immunization records) with the appropriate school district for the purpose of providing care and treatment, if applicable.

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HIPAA RELEASE: **I hereby authorize CHANGE, Inc.'s Family Medical Care Health Centers, providers and/or staff to discuss my medical information with the following person(s); This does not allow the release of records to this person(s):**

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Patient's/Guardian's Signature **Date**

Relationship to Patient