ARBOR FAMILY HEALTH

A DIVISION OF INNIS COMMUNITY HEALTH CENTERS, INC.

PATIENT INFORMATION

Dear Patient: We are a non-profit clinic that provides low cost health care on a sliding scale. Visit costs for patients are determined by a sliding fee scale that is calculated based on income and household size. Due to new federal reporting regulations, the following information is now required for each patient. Please note that all information is confidential. We appreciate your cooperation with these new reporting requirements and will need to collect this information on an annual basis.

Today's Date ____/____/____

PATIENT INFORMATION

(Please give your driver's license to the receptionist)

Patient's Last Name	First	Middle	Social Security No

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	DOB	Age	Nickname: Previous Names:

Home Address (Street) (City) (State) (Zip)

Mailing Address (Street or P.O. Box) (City) (State) (Zip)

Home Phone:	Cell Phone:	Work Phone:

E-Mail Address

Occupation	Employer	Employer Address

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male (Female to Male) ☐ Transgender Female (Male to Female) ☐ Other ☐ Prefer not to disclose ☐ Genderqueer, neither exclusively male or female

Birth Sex: ☐ Male ☐ Female

Sexual Orientation: ☐ Straight (Not Lesbian or Gay) ☐ Lesbian or Gay ☐ Bisexual ☐ Other ☐ Don't Know ☐ Prefer not to disclose

IN CASE OF EMERGENCY

Name of Local Friend of Relative	Relationship to Patient	Home Phone:	Work Phone:	Cell Phone:

Preferred Method of Contact (Check TWO) ☐ Home Phone ☐ Work Phone ☐ E-mail ☐ Cell Phone ☐ Postal Mail ☐ Fax

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

Is this patient covered by insurance? ☐ Yes ☐ No

If YES, please check one: ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Other:

Name of Primary Insurance	Policyholder's Name	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other — Policyholders DOB

Name of Secondary Insurance	Policyholder's Name	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other — Policyholders DOB

Any Additional Insurance	Policyholder's Name	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other — Policyholders DOB

PARENT/GUARDIAN INFORMATION

(To be completed if the patient is a minor)

Mother/Guardian's Name	Mother's Maiden Name	Mother/Guardian's DOB	Mother/Guardian's SSN	Mother/Guardian's Phone #

Father's Name	Father's DOB	Father's SSN	Father's Phone #	Patient's Next of Kin

Address (if different from above)

Person Responsible for Payment	Relationship to Patient	Occupation

Employer	Employer Address	Employer Phone No.

ARBOR FAMILY HEALTH

For Internal Use Only:

Patient Account #: _____ Patient Name: _____ Patient DOB:_____

YOU HAVE THE RIGHT TO OPT OUT OF HIE/HIV – *Please Request OPTIONAL SERVICES Form to opt-out*

Health Information Exchange

When you seek medical treatment at an organization participating in a HIE, your health information is accessible. ***If you choose to opt out of HIE, your health information cannot be accessed or shared even in an emergency situation.***

HIV Screening

As an FQHC we participate in many federal programs as part of the Ending of the HIV Epidemic initiative. All patients' ages 15-65 will be screened for HIV annually. ***If you choose to opt-out you will need to complete a consent form for HIV screening if you request to be screened in the future.***

I hereby assign all payments of benefits for Behavioral Health/Dental/Medical Services rendered to myself or dependents to Innis Community Health Center, Inc. I understand that I am financially responsible for any charges incurred and/or not paid. I agree to pay any deductible, co-insurance; copay, for any service(s) received, regardless of my insurance status now or at any time hereafter execution of this form. I also hereby authorize release of information required in the course of these services as may be needed to process my claims. Claims cannot be filed without your signature.

I hereby authorize or consent to the diagnostic and/or therapeutic treatment for myself or the minor named below that may be considered necessary or advisable by the professional healthcare providers of the clinic, I consent to on-line, audio and video communication. I understand the risks, benefits and limitations to telehealth/teledentistry services and patient portal access. I consent for medical photographs to be taken of me or the person for whom I am a legal guardian. I understand that this information may be used in m medical record of identification purposes. I also consent Innis Community Health Centers, Inc. Arbor Family Health to access my prescription information within the Rx eligibility verification network for continuity of care within my provider group.

Motor Vehicle Accident and Worker's Compensation: I understand that I am responsible for 100% of the bill for treatment received for a motor vehicle accident or worker's compensation incident, and that I must pay the bill in full on the day treatment is rendered. I also understand that I may not have to pay for treatment rendered if a written document is provided by my lawyer or claim adjustor (representing a workmen compensation or motor vehicle accident case) promising to pay the amount in full. I agree that this consent form will be valid for one year for medical and/or dental services provided to me. I agree that a photocopy of this form may be used in lieu of the original.

_____ _____ _____

Patient/Guardian Signature **Patient Name (PRINTED)** **Date**

This consent may be withdrawn or modified at any time with written permission of the patient, parent/legal guardian to Innis Community Health Centers, Inc., Arbor Family Health. A copy of this consent can be given to parents or guardians upon request.

ADDITIONAL PATIENT DATA

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student ☐ None

Are you a Veteran? ☐ Yes ☐ No

Preferred Language:

Housing Status: ☐ Rent/Own ☐ Street ☐ Homeless ☐ Doubling Up ☐ Transitional ☐ N/A

Agricultural Status: ☐ Migrant Worker ☐ Seasonal Worker ☐ Dependant of Migrant ☐ Dependant of Seasonal ☐ N/A

Primary Care Physician:

Primary Dentist:

Preferred Pharmacy:

Advanced Directive/Living Will? ☐ Yes ☐ No

***If YES, did you bring a copy with you today? ☐ Yes ☐ No

Do you have access to transportation for health appointments? ☐ Yes ☐ No

Annual Household Income: ☐ Less than $10,000 ☐ $10,001-$20,000 ☐ $20,001-$40,000 ☐ Prefer not to disclose ☐ $40,001-$60,000 ☐ $60,001-$100,000 ☐ $100,000+

Number of people living in your household:

PRIVACY HIPAA AUTHORIZATION FORM

Disclaimer: This document is provided solely for referenced purposes. Covered Entities under HIPAA are advised to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.

I, _____ give permission to Innis Community Health Center to:

☐ Use the following protected health information, and/or ☐ Disclose the following protected health information to:

(Name(s) of entity to receive information)

_____

_____

_____

(Relationship to Name listed)

_____

_____

_____

Information to be given (check all that apply):

☐ Medical Records ☐ Treatment Records ☐ Diagnostic Records

☐ Other: _____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations (HIPAA).

You may refuse to sign this authorization, Your refusal to sign will not affect your ability to obtain treatment or payment or eligibility of benefits.

You may inspect or copy protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in person at the office location or in writing at any time by sending written notification to Innis Community Health Center at 6450 Hwy 1, Batchelor, LA 70715. your notice will not apply to actions taken by or any actions prior to this office receiving a written and signed request revoking the authorization.

NOTICE OF PRIVACY PRACTICES: I have been provided with and understand the contents of the Notice of privacy Practices for Innis Community Health Centers, Inc. and its' entities. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations at Innis CHC, Inc. and its' entities are not required to agree to the restrictions.

_____ _____

Signature of Participant or Personal Representative **Date**

ARBOR FAMILY HEALTH

A DIVISION OF INNIS COMMUNITY HEALTH CENTERS, INC.

AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL INFORMATION

I,_____ **DOB:**_____ **SS#** _____

AUTHORIZE: _____ **DR:** _____ **ADDRESS:** _____

To release a copy of all medical records in the possession of the above identified practice concerning my illness and/or treatment during the period of _____ and _____ .

Purpose of this authorization is: (place a check mark in the blank that applies)

___ Further Medical Care ___ Personal ___ Changing Providers ___ Legal

I authorize the release of the following protected health information: (place a check mark in the blank that applies)

___Entire Record ___ Treatment or Test ___ Immunizations ___OTHER:_____

___Laboratory/X-ray Reports ___ Medical History, Examination, Reports

This authorization includes release of information concerning HIV testing, diagnosis, or treatment of HIV, HIV treated conditions, drug/alcohol abuse, and drug related conditions and/or psychiatric or psychological diagnosis. This authorization also authorizes the release of any and all medical records received by the office medical practice from any other healthcare facility or provider. I understand the copy of records sent to this clinic from a previous healthcare facility or provider may or may not represent a complete medical record.

Please release the above information as stated and authorized material to: (check clinic)

	CLINIC	ADDRESS	PHONE	FAX
	INNIS COMMUNITY HEALTH CENTER	6450 LA HWY 1 BATCHELOR, LA 70715	(P) 225-492-3775	(F) 225-492-3772
	LIVONIA COMMUNITY HEALTH CENTER	8387 Newfield Dr. PO Box 250 LIVONIA, LA 70755	(P) 225-412-0202	(F) 225-412-0366
	MARINGOUIN COMMUNITY HEALTH CENTER	77575 Landry Dr. MARINGOUIN, LA 70757	(P) 225-625-2105	(F) 225-625-2109
	NEW ROADS COMMUNITY HEALTH CENTER	230 Roberts Drive, Suit H. PO Box 1127 NEW ROADS, LA 70760	(P) 225-618-7800	(F) 225-238-8330
	NEW ROADS COMMUNITY HEALTH CENTER SPECIALITY SERVICES (Behavioral Health)	230 Roberts Drive, Suit H. PO Box 1127 NEW ROADS, LA 70760	(P) 225-618-5959	(F) 225-238-8330
	POINTE COUPEE SCHOOL BASED CLINIC	8460 Pointe Coupee Rd. New Roads, LA 70760 PO Box 250 LIVONIA, LA 70755	(P) 225-638-3767	(F) 225-638-4058
	LIVONIA SCHOOL BASED HEALTH CLINIC	8387 Newfield Dr. PO Box 250 LIVONIA, LA 70755	(P) 225-412-0404	(F) 225-412-0342
	BRUSLY SCHOOL BASED HEALTH CENTER	230 N. Vaughn Dr. BRUSLY, LA 70719	(P) 225-344-0008	(F) 225-343-0623

Patient's Signature or Legal Guardian Date

Witness of Patient's Signature or Legal Guardian Date
(Medical Staff Member)

Revised: 10/2022

Name: _____ DOB: _____

Race and Ethnicity (Select All that Apply)

What is your Ethnicity?

- Mexican, Mexican American, Chicano
- Puerto Rican
- Cuban
- Another Hispanic, Latino/a, or Spanish Origin
- Hispanic, Latino/a, Spanish Origin, Combined
- Not Hispanic, Latino/a, or Spanish Origin
- Unreported/Chose Not to Disclose Ethnicity

What is your Race?

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Other pacific islander
- Guamanian or Chamorro
- Samoan
- Black/African American
- White
- More than one race
- Unreported/Chose Not to Disclose Race

Name: _____ Date of Birth: _____

Total gross annual salary: _____ (Must attach copies of latest check stubs or W-2's)

Please place a check mark by the following which may apply to you, your spouse or your children and give specific amounts

Application for Slide Scale Fee Privileges to retain sliding scale fee privileges PROOF OF INCOME MUST BE SUPPLIED WITHIN 5 DAYS OF THIS APPLICATION. (Example of proof of income includes but not limited to: Recent pay stub for all working members and evidence of other income, current award letter or printout from the Social Security Administration, alimony or child support, a statement on employer letterhead stating average hours worked a week and the pay rate, or a recent bank statement.) *If proof of income is not received or you refuse to supply this information within this time, you will be responsible for 100% of the bill.* Please complete the following household information: Do you or anyone residing in your household receive any of the following?

		Yes	No	Amount			Yes	No	Amount
A	Employment				K	Social Security for spouse, children or others			
B	Unemployment				L	Food Stamps			
C	Worker's Compensation				M	Any regular support for anyone not living with you			
D	Strike Benefits				N	Government Employee Pension			
E	Veteran's Benefits				O	Private insurance and/or regular insurance annuity payments			
F	Job Training Funds				P	Dividends			
G	Alimony				Q	Interest Payments			
H	Child Support				R	Rental Payments			
I	Military Family Allotments				S	Royalties			
J	AFDC				T	Income from estate trusts			

Please list the name of each member of your household below (If not enough space, please use back)

Name	Date of Birth	Income	Weekly, Bi-Weekly, Bi-Monthly, Monthly

I certify that I have read or have had read to me the above questionnaire and that all of the information is correct. I understand that failure to make full disclosure of my true income is an act of fraud and can be punishable by either a fine or imprisonment according to federal law.

Patient/Guardian Signature _____ Today's Date

2024 Sliding Scale Discounts

You may be eligible for **DISCOUNTED SERVICES** —even with private insurance!

Arbor Health Clinics offer discounted services to **ALL** who qualify. Find out if you are eligible on the scale below.

How Many People in Your Household?	INCOME LEVEL Pay only $20	INCOME LEVEL Pay 25%	INCOME LEVEL Pay 50%	INCOME LEVEL Pay 75%	INCOME LEVEL Pay 100%
1	$0 – $15,060.00	$15,060.01 – $20,029.80	$20,029.81 – $24,999.60	$24,999.61 – $30,120.00	$30,120.01 +
2	$0 – $20,440.00	$20,440.01 – $27,185.20	$27,185.21 – $33,930.40	$33,930.41 – $40,880.00	$40,880.01 +
3	$0 – $25,820.00	$25,820.01 – $34,340.60	$34,340.61 – $42,861.20	$42,861.21 – $51,640.00	$51,640.01 +
4	$0 – $31,200.00	$31,200.01 – $41,496.00	$41,496.01 – $51,792.00	$51,792.01 – $62,400.00	$62,400.01 +
5	$0 – $36,580.00	$36,580.01 – $48,651.40	$48,651.41 – $60,722.80	$60,722.81 – $73,160.00	$73,160.01 +
6	$0 – $41,960.00	$41,960.01 – $55,806.80	$55,806.81 – $69,653.60	$69,653.61 – $83,920.00	$83,920.01 +
7	$0 – $47,340.00	$47,340.01 – $62,962.20	$62,962.21 – $78,584.40	$78,584.41 – $94,680.00	$94,680.01 +
8	$0 – $52,720.00	$52,720.01 – $70,117.60	$70,117.61 – $87,515.20	$87,515.21 – $105,440.00	$105,440.01 +
Over 8	Add $5,380 for each person over 8	Add $5,380 for each person over 8	Add $5,380 for each person over 8	Add $5,380 for each person over 8	Add $5,380 for each person over 8

Once qualified, you must show us valid proof of income to receive your discounts.
Accepted documents: Tax Return, Recent Check Stub, Bank Statement, Social Security Letter or Food Stamp Award Letter. Please fill out a Sliding Scale Form available at the front desk. **If you have questions, just ask us!**

Based on 2024 Poverty Guidelines, U.S. Health & Human Services
https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Our Care Coordinators

Our Arbor Family Health Care Coordinators are here to answer ALL of your questions!
We can help you:

- Apply for Medicaid/Medicare
- Apply for SNAP benefits
- Section 8 Affordable Housing
- Assistance with Transportation
- Obtain a cell phone
- Prepare you for a job interview
- Network with local job opportunities
- Assist you in learning how to be a successful employee

Give us a call today and ask to speak with a Care Coordinator!

1-888-711-3785

ARBOR FAMILY HEALTH

ARBOR FAMILY HEALTH

A DIVISION OF INNIS COMMUNITY HEALTH CENTERS, INC.

REV 05/2018

Consent for Dental Treatment
Acknowledgement of Receipt of Information

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand and we are ready to answer any of your questions or explain anything to you. Any alternatives in the recommended treatment, including no treatment, have been explained to me. In general terms the contemplated dental treatment is:

There are risks associated with any dental treatment. This includes the administration of any local anesthetic agent to site and pre medication prior to dental care being rendered. Some of these risks/complications are, but are not limited to, the following:

Infection
Bleeding
Failure of wound to heal
Injuries to adjacent teeth and or hard or soft tissue
Paresthesia or numbness of: tongue, and or mouth and or face
Fracture of mandible (lower jaw) or maxilla (upper jaw)
Opening between mouth and sinus or mouth and nose
Tooth or fragment in maxillary sinus
Incomplete removal of teeth
Dry socket
Loss of teeth
Lose of bone
Slough (unanticipated loss of hard and/or soft tissue)
Injury to adjacent structures
Instrument breakage
Breakage of root(s) and retained root fragments
Swallowing and/or aspiration of objects
Allergic reaction to drugs
Trismus (jaw pain or difficulty opening mouth)
Failure or treatment to accomplish its purpose
Death (in rare instances)
Bacterial Endocarditis
Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s)

Acknowledgement

I acknowledge that I have read, or that it has been read to me and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction I hereby authorize and direct the dentist and/or associates, hygienists, assistant of their choice to perform the diagnosis, dental treatment. This consent form will remain valid until revoked by me in writing.

_____

Patient Name

_____ _____

Signature of Responsible Party Date

ARBOR FAMILY HEALTH

Patient Name:	**MEDICAL HISTORY**
Date of Birth:	ACCOUNT NUMBER (office use only)

AIDS/HIV Positive.....☐Yes ☐No
Arthritis/Rheumatism..☐Yes ☐No
Artificial Heart Valve/
Pacemaker.....☐Yes ☐No
Artificial Joints.....☐Yes ☐No
(Hip, Knee, etc) .....☐Yes ☐No
Asthma.....☐Yes ☐No
Blood Transfusion.....☐Yes ☐No
Cancer.....☐Yes ☐No
Specify_____
Chemotherapy.....☐Yes ☐No
Chest Pain.....☐Yes ☐No
Congenital Heart Disease ..☐Yes ☐No
Diabetes.....☐Yes ☐No
Emphysema.....☐Yes ☐No

Epilepsy/Seizures.....☐Yes ☐No
Fainting/Dizzy Spells.....☐Yes ☐No
Glaucoma.....☐Yes ☐No
Hay Fever/Allergy/Hives.....☐Yes ☐No
Heart Murmur.....☐Yes ☐No
Heart (Surgery, Disease, ...☐Yes ☐No
Attack) .....☐Yes ☐No
Hemophilia.....☐Yes ☐No
Hepatitis A, B, C ..... ☐A ☐B ☐C
High/Low Blood Pressure....☐Yes ☐No
Kidney Trouble.....☐Yes ☐No
Liver Disease/Yellow
Jaundice.....☐Yes ☐No
Metal/Plates/Screws.....☐Yes ☐No
Specify_____

Mitral Valve Prolapse.....☐Yes ☐No
Nervous/Anxious.....☐Yes ☐No
Neurological Disorders.....☐Yes ☐No
Osteoporosis.....☐Yes ☐No
Radiation Therapy.....☐Yes ☐No
Rheumatic Fever.....☐Yes ☐No
Sickle Cell Disorder.....☐Yes ☐No
Sinus Trouble.....☐Yes ☐No
Stroke.....☐Yes ☐No
Tuberculosis.....☐Yes ☐No
Tumors.....☐Yes ☐No
Thyroid Problems.....☐Yes ☐No
Ulcers.....☐Yes ☐No

Do you have or have you had any disease, condition, or problem not listed? .....☐Yes ☐No
Women: Are you pregnant or think you could be pregnant? .....☐Yes _____Months ☐No Nursing? .....☐Yes ☐No
Do you Smoke? .....☐Yes ☐No # of Years _____ Packs per day_____
Do you Vape? .....☐Yes ☐No Use an Ecigerette? .....☐Yes ☐No Smoke Marijuana? .....☐Yes ☐No
Do you Dip or Chew? ....☐Yes ☐No Do you use street drugs? ...☐Yes ☐No Type_____
Have you ever been in drug rehab or alcohol treatment? ....☐Yes ☐No
Have you ever had surgery of any type? .....☐Yes ☐No If **YES,** please list: _____
Are you taking the following?
Anticoagulants (blood thinners) .....☐Yes ☐No
Medicine for high blood pressure.....☐Yes ☐No
Tranquilizers.....☐Yes ☐No
Other.....☐Yes ☐No

Provider Initials: _____

List Medications: _____
Allergies:
Penicillin/Amoxicillin.....☐Yes ☐No
Latex.....☐Yes ☐No
Other: _____

FAMILY MEDICAL HISTORY (Which of the following medical conditions apply to you or an immediate family member?)

Y	N	Condition & Details	Relationship to patient (Mother, Sister, etc.)	Y	N	Condition & Details	Relationship to patient (Mother, Sister, etc.)
		Asthma				Diabetes	
		Cancer				Seizures	
		High Blood Pressure				Sudden death before age 50	
		Heart Disease/Heart Attack				Sickle Cell	
		Emotional/Mental Health Concerns				Tuberculosis	
		Nervous/Mental Disorder				Other:	
		Other:				Other:	

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____ **Date:** _____