Hopewell Health Centers, Inc.

Help us get to know you! By reviewing the information below, our team can work together to meet your individual needs.

Patient General Information

Last First MI | Date of Birth | Social Security #

Address (Street & PO Box) | Home Phone | Cell Phone | Msg/Work Ph | Email

City | State | Zip Code | County | Employer

Occupation | By whom were you referred?

Emergency Contact: ______ Relationship ______ Name ______ Phone

Preferred Pharmacy: ______

Patient Demographic Information

Birth Sex		Learning Preference		Language		Veteran	
	Male		Oral		English		YES
	Female		Visual		Other		NO
	Unknown		Written				

NOTE: To provide clarification or further information for this section or any section of this document, go to Page 4: Miscellaneous Comments & Information.

Marital Status		Gender Identity		Sexual Orientation	
	Single		Male (M)		Lesbian/Gay/Homosexual
	Married		Female (F)		Straight
	Divorced		Transgender (M to F)		Bisexual
	Partner		Transgender (F to M)		Don't know
	Unknown		Neither exclusively M or F		Choose not to disclose
	Widowed		Choose not to disclose		Something else:
	Legally separated		Something else:		

Race			Ethnicity	
	White	Asian		Hispanic or Latino
	Black	Native Hawaiian		Not Hispanic or Latino
	African American	Other Pacific Islander		Decline to specify
	American Indian	Decline to specify		Other:
	Alaskan Native	Other:		

Patient Social Services Involvement

What other agencies, service offices or health providers are currently working with you?

Department of Job and Family Services

Parole/Probation Officer = ______

Children Services: County and caseworker: ______

If involved with Children Services, do you/your family have a case plan? Yes No

Legal Service/Lawyers/Courts: ______

Medical Service Providers: ______

Home Health: ______

Other Service Providers: ______

Hopewell Health Centers, Inc. Patient Information - Continued

Patient Medications

CURRENT Medications (Prescription, Over the Counter, Vitamins, Herbal)

Please fill this out to the best of your ability. All information below must be included.

No medications Additional medications on page 4: Miscellaneous Comments & Information

Medications	Dose & Frequency	Prescribed by	How long taken?	Reason for use	Helpful?	Take regularly?
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N

Adult Patient only (if the patient is a child, go directly to the next section)

Do you currently have a legal guardian? NO YES Do you currently have a payee? NO YES

If yes: Guardian Name____________________ Address:________________________________ Phone:___________

Payee Name______________________ Address:________________________________ Phone: ___________

Do you have an Advance Directive? NO YES Don't know what this is

If yes, please give your service provider a copy of your Directive. If you would like more information about Advance Directives, please ask service provider.

Child Patient only (if the patient is an adult go directly to the next section)

Name of Person completing form: ______________________________

Relationship: Parent Foster parent Children Services worker Other: ______________________

Custody: Share custody Custodial parent Single parent (never married/widowed) with custody

Non parental: Relationship: ________________Phone (if different)_________ How long have you had custody?_______

Other: _________________________________

Patient Financial & Billing Information

Responsible Party Self Other Relationship ____

_______________________________ _________________________________ __________________ ____ ________

Name Address City State Zip

Insurance Information

Primary insurance ________________________________

Address ____

Insurance ID ____________________________________

Policy Holder Name _________________________________

_________________ _______________________

Social Security # Date of Birth

Employer ______________________________________

Secondary insurance ________________________________

Address ____

Insurance ID ____________________________________

Policy Holder Name _________________________________

__________________ _______________________

Social Security # Date of Birth

Employer ______________________________________

Provide annual income information for your household, below

Total number in household: _____ number of persons related by birth, marriage, adoption, or guardianship, living in the same house
List ALL Household Members and Annual Income (if applicable). Annual Income should include all sources - wages, child support, social security, etc. For help calculating annual income amounts, see income worksheet on page 4.

Name	DOB	Relationship	Annual Income
			$ /yr
			$ /yr
			$ /yr
			$ /yr
			$ /yr
			$ /yr
			$ /yr
			$ /yr

Total household income: $______________/yr

If there are more than 8 members in the household, provide further information on page 4: Miscellaneous Comments & Information

I am refusing the Sliding fee discount   I am applying for the Sliding Fee discount

Proof of Income must be provided to receive a Sliding Fee discount. Provide proof for all household members: pay stubs, child support, unemployment, disability, social security (must be award/benefit letter).

For Office Personnel Use Only
Sliding Fee discount_______________   Sliding Fee Expiration_______________

When filling out this document on-screen, you must complete this Acceptance section. NOTE: By selecting "I Accept," you are confirming your intent to sign this document electronically.

ACCEPTANCE OF ELECTRONIC SIGNATURE:

I ACCEPT. I am signing this document by typing my name in the Signature field below.

I DO NOT ACCEPT. I will print out and sign a paper copy and deliver or mail it to my healthcare provider.

SIGNATURE:
I certify that, as of this date, all the information I have provided in this document is correct to the best of my knowledge. I authorize payment of all insurance policy benefits to be paid directly to Hopewell Health Centers, Inc. This will include information necessary to determine eligibility for public funds for behavioral health services, to enroll me/my child in GOSH, and to obtain payment for treatment rendered which is submitted to appropriate ADAMHS Board or the county of my residence. I also understand that failure to notify Hopewell Health Centers, Inc. of any additions or corrections will terminate my eligibility for the sliding fee, should I qualify. Any false statement will jeopardize the discount and result in the requirement of full payment of my account.

Patient Signature ____________________________________ Date _______________

Parent or Legal Guardian ______________________________ Date _______________

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Income worksheet

Use the spaces below to calculate annual income from hourly wages or weekly, bi-weekly, or monthly income - or to add multiple sources of income together for one household member. Use the results to fill in the income information requested on page 3.

Convert hrly , weekly, biweekly, or monthly amounts to annual income: Annual income

Hourly wage Hours worked per week Weeks worked per yr

Weekly income Weeks worked per yr

Every two week income Weeks worked per yr

Monthly income Months per yr

Add up multiple annual income amounts for a household member. Use annual amounts.

Employment : Social Security: Child support:

Other 1 : Other 2 : Other 3:

Total:

To reuse the worksheet,

Miscellaneous comments and information

Add any clarifications or additional information in the space below.

Patient Signature ______________________________________ Date ______________

Parent or Legal Guardian ________________________________ Date ______________