Lifecare
Family Health & Dental Center

Patient Name: _____ **Date of Birth:** _____

AGREEMENT OF TREATMENT EXPECTATIONS AND MEDICAL HOME RESPONSIBILITIES

This is an agreement between two parties: the Health Center and the Patient.

The purpose of this document is a positive one. It attempts to make the clear rights and responsibilities of both parties. It says *who* is to do *what*.

A medical home is a care team working to provide you with the best care possible. We want to include you in making health care decisions. We will help you coordinate your care with providers outside of Lifecare when needed. We offer clinical advice during and after hours along with early morning appointments.

We promise to treat you to the best of our abilities, consistent with the standards of care in our community. You, in turn promise to be as understanding, cooperative, and responsible as possible.

This Health Center has a zero tolerance for violence or threat of violence of any kind. Therefore, there will not be any attempt or threat to kick, hit, or otherwise harm any staff member, patient, or visitors. Furthermore, neither party will yell or use profanity when addressing any staff member, patient, or visitors.

I have read (or have had read to me) the "Agreement of treatment Expectations" and fully understand its contents. I have been given an opportunity to ask questions. Any violation of this agreement may result in permanent dismissal from the office.

LEGAL GUARDIAN – MUST BE COMPLETED IF PATIENT IS UNDER THE AGE OF 18

Patient Name/Legal Guardian: _____
Social Security Number: _____ Relationship to Patient: _____
Street Address if different from above: _____
City, State, Zip Code: _____ County: _____

Patient Name: _____ Date: _____

If not the Patient, Relationship to Patient: _____

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Financial Agreement

I hereby consent to all treatment deemed necessary by the staff of Lifecare Family Health & Dental Center, Inc. I authorize the Lifecare Family Health & Dental Center, Inc. (LIFECARE FHDC) to use, disclose, and/or receive any or all information relating to my treatment. My provider may contact any other covered entity that has provided services to me for the purpose of obtaining further diagnosis.

LIFECARE FHDC has made prior arrangements with many health plans to accept direct payments. LIFECARE FHDC will bill those plans for which it has made prior arrangement and will only require you to pay the authorized Co-pay at the time of service. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the physician or group indicated on the claim. I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my insurance. My insurance policy, if applicable, is a contract between me and my insurance company. LIFECARE FHDC is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim.

As a courtesy to the patient, LIFECARE FHDC will submit claims to any insurance company. If the patient's coverage is with a plan that LIFECARE FHDC does not have prior arrangement, the charges for the patient's care and treatment are the patient's responsibility and due in full at the time of service.

I understand that unless other arrangements have been made in advance by either me or my health coverage provider, payment is due at the time of service. For all services rendered to minors, the custodial parent or legal guardian will be responsible for all charges.

For the patient's convenience LIFECARE FHDC will accept Visa, MasterCard, Cash, and Personal Check. There will be a $10.00 fee charged to patients for all non-sufficient funds checks and the patient will be required to pay cash for all future visits.

I further attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the number of family members listed are all solely dependent on that income. I verify my income level is truthful. I understand that LIFECARE FHDC is not in the business of extending credit and I agree to pay the above practice at the time its bill is presented. If prompt payment is not made, LIFECARE FHDC may take action to collect its charges.

INSURANCE INFORMATION
Primary Insurance: _____ID#:_____ Group#: _____ Policyholder Name: _____ Policy Holder D.O.B.: _____ Relationship to Patient: _____
Secondary Insurance: _____ID#:_____ Group#: _____ Policyholder Name: _____ Policy Holder D.O.B.: _____ Relationship to Patient: _____

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Financial Agreement- continued

Lifecare receives funding to offset the costs of treating uninsured or underinsured patients. We are required to report certain demographics on all of our patients including race, family size, and income. Reporting these items assists us to receive funding to continue providing care to all of our patients. Reported information **does not** contain your name, address, or social security information.

Please circle household size and check the correct income box in the same line:

Household members	Income less than:	Income between:	Income between:	Income more than:
1	[ ] $15,060	[ ] $15,061 - $20,783	[ ] $20,784 - $24,849	[ ] $28,614
2	[ ] $20,440	[ ] $20,441 - $28,207	[ ] $28,208 - $33,726	[ ] $33,727
3	[ ] $25,820	[ ] $25,821 - $35,632	[ ] $35,633 - $42,603	[ ] $42,604
4	[ ] $31,200	[ ] $31,201 - $43,056	[ ] $43,057 - $51,480	[ ] $51,481
5	[ ] $36,580	[ ] $36,581 - $50,480	[ ] $50,481 - $60,357	[ ] $60,358
6	[ ] $41,960	[ ] $41,961 - $57,905	[ ] $57,906 - $69,234	[ ] $69,235
7	[ ] $47,340	[ ] $47,341-$65,329	[ ] $65,330-$78,111	[ ] $78,112
8	[ ] $52,720	[ ] $52,721-$72,754	[ ] $72,755 - $86,988	[ ] $86,989

REDUCED RATE PROGRAM

Lifecare offers a Reduced Rate Program as our way to offer services at a lower cost to families who meet certain requirements. The Reduced Rates are divided into different categories based on household size and gross income. Patients that qualify for the program would pay for services according to what finical category they fall into.

Are you interested in applying for our Reduced Rate Program? [ ]YES [ ]NO

I UNDERSTAND THAT THERE MAY BE CHARGES IN ADDITION TO MY COPAY BASED ON THE CLINIC'S SLIDING FEE SCALE. I AGREE TO PAY SAID CHARGES.

Patient Printed Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

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PATIENT DEMOGRAPHIC FORM

First Name: _____ **Middle initial:** _____ **Last Name:** _____

Date of Birth: _____ **Social Security Number:** _____

Address: _____ **Apt./Unit/Lot #** _____**City:**_____

Marital Status: [ ]single [ ]married [ ]divorced [ ]widowed [ ]separated

Employment Status: [ ]full time [ ]part time [ ]unemployed [ ]self-employed [ ]retired [ ] seasonal

Occupation: _____**Education (highest grade/degree)**: _____

Primary Phone Number: _____ **Additional Phone Number:** _____

Email Address_____

Preferred Contact Method: [ ] Home Phone [ ]Cell Phone [ ] Patient Portal

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

How Did You Hear About Us? (circle one from below)

Newspaper Outreach Event/Community Friend Employee of Lifecare Ad/TV/Website

Race: [ ]White [ ]Black [ ]Native American/Alaska Native [ ]Asian Indian [ ]Chinese [ ]Filipino [ ]Japanese [ ]Korean [ ]Vietnamese [ ]Other Asian [ ]Native Hawaiian [ ]Samoan [ ]Guamanian or Chamarro [ ]Other Pacific Islander [ ]More than one race [ ]Choose not to disclose	**Sex at Birth:** [ ]Male [ ]Female **Preferred Pronouns:** [ ]he/him [ ]she/her [ ]they/them [ ]Other: _____	**Sexual Orientation:** [ ]Lesbian/Gay [ ]Straight [ ]Bisexual [ ]Something else:_____ [ ]Don't know [ ]Choose not to disclose
Ethnicity: [ ]Non-Hispanic [ ]Mexican, Mexican American, Chicano/a [ ] Puerto Rican [ ] Cuban [ ] Another Hispanic, Latino/a or Spanish Origin [ ]Choose not to disclose	**Veteran:** [ ]Yes [ ]No **Check if any of these apply to you:** [ ]Homeless [ ]Live in public housing **Preferred Language:** [ ]English [ ]Spanish [ ]Other: _____	**Gender Identity:** [ ]Male [ ]Female [ ]Non-Binary [ ]Transgender male to female [ ]Transgender female to male [ ]Other: _____ [ ]Choose not to disclose

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HIPAA
LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your last signature below unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Please list the date of expiration if earlier than the end of the calendar year:

_____

Right to revoke or terminate as stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Compliance Officer. You may revoke an authorization at any time, in writing, except to the extent that your health care provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____: By initialing the following you acknowledge that you are aware of/and how to obtain a copy of the Notice of Privacy Policy, and that should you want a paper copy one can be provided at your request. It can also be viewed electronically on our website: https://www.lifecarefhdc.org/

Non-Conditioning Statement: The practice places no condition to sign this authorization on the delivery of health care or treatment.

Re-disclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature: _____

Date: _____ (must be signed and dated each year)

*You have a right to receive a copy of signed authorization upon request

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Release Of HIPPA Protected Information

(Allow the clinic to discuss your health information with the individuals listed below)

Purpose of Request (who is authorized to receive health information) - I authorize the practice to disclose or provide health information, about me to the individual(s) listed below. (Please list each family member, friend, or other individual to receive Protect Health Information).

Name: _____
Phone Number: _____ Relationship: _____

Name: _____
Phone Number: _____ Relationship: _____

Name: _____
Phone Number: _____ Relationship: _____

Name: _____
Phone Number: _____ Relationship: _____

Description of Information to be disclosed – I authorize the practice to disclose the follow Protected Health Information about me to the person or persons identified above.

☐ Entire patient record, **or** circle **only** those items of the record to be disclosed

☐ Office notes ☐ lab results ☐ x-ray results
☐ Record of HIV and communicable disease record
☐ Hospital / nursing home / home health / hospice and other physician records
☐ Records of mental health or substance abuse treatment.

☐ Other (please specify): _____

Purpose of disclosure (please record the purpose of the disclosure, or check patient request):

☐ Patient request
☐ Other (please specify):_____

Patient Signature: _____

Date: _____ (must be signed and dated each year)

Patient Name: _____ **Date of Birth:** _____

Lifecare Family Health & Dental Center Appointments Contract

Per; Lifecare Family Health and Dental Center MED 18 Attach: A

Your Lifecare Family Health & Dental Center (LFHDC), providers want to ensure that you and other area residents have access to high quality medical, dental, vision, and behavioral health care when you need it. To ensure maximum access to services for all of our patients, please be aware of the following appointment policy.

Contact Information: It is your responsibility to keep your current address and phone number on file with FHDC. Please keep LFHDC up to date anytime your information changes.

Scheduled Appointments: Although Lifecare Family Health & Dental Center will make every effort to remind you of your upcoming appointment, however, you are ultimately responsible for remembering your appointment date and time.

Canceling Appointments: If you cannot make your scheduled appointment, you must notify us at least 4 hours prior to the appointment. Failure to provide at least four (4) hours' notice counts as a missed appointment.

Missed Appointments: Missed appointments are monitored because of the critical lack of access to medical services in our area. Patients who miss an appointment will receive notification advising them that they have missed an appointment which could impact their health and wellness.

Patients who miss 3 appointments will receive a warning notification of 3 or more missed appointments and possible wait time to be seen by provider, with no appointments scheduled after 2:00 PM.

Please contact the health center if you have any questions about our Appointments Policy.

_____: By initialing I understand and agree to abide by this Appointments Contract.

Patient Signature: _____

Date: _____ (must be signed and dated each year)

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DENTAL HEALTH HISTORY

Primary Care Physician: _____**Phone:** _____
Medical Specialists: _____ **Phone:** _____

Have you had any major health problems in the past 5 years? (serious illness, hospitalization, surgery)

_____
_____

Do you have a dental emergency or major dental problem?

_____
_____

How long has it been since your last dental appt? _____

Are you required to take an antibiotic before any dental treatment? [ ] YES [ ] NO
If yes, why?

_____

Do you have any of the following: (please circle)

sensitivity hot/cold	clicking/popping of jaw	reconstructive surgery	burning tongue
bleeding/sore gums	food impaction now	biting sensitivity	periodontal surgery
swelling	grinding/clenching	headaches	orthodontics
pain in teeth now			

Allergies: Are you allergic to or have you had a reaction to: (please circle)

penicillin	latex	ibuprofen	any metals
sulfa drugs	local anesthetic	sedatives	food
other antibiotics	fluoride	aspirin	codeine
acetaminophen			

Medications: Are you currently taking any medications, over the counter drugs, or natural/herbal supplements? [ ] YES [ ] NO

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Do you take any blood thinners? (Plavix, Coumadin, Warfarin, or Aspirin)? [ ]YES [ ]NO

medication/supplement	strength/dosage	# of times a day	reason

Important health information: Do you use, have or had, any of the following? (please circle)

artificial joints/limbs	cancer	rapid weight loss	kidney disorder/dialysis
heart stents	chemotherapy	radiation therapy	neurologic disorder
artificial heart valves	asthma/inhalers	cleft palate/lip	narcotic use
pace maker	TB	alcohol use	marijuana use
heart attack	arthritis	cold sores	drink cola/pop
stroke	systemic lupus	hemophilia	tobacco use
high/low blood pressure	rheumatic fever	AIDS/HIV	Type_____ How much per day? _____ _____
heart murmur	anxiety attacks	hepatitis A/B/C	
mitral valve prolapse	eating disorder	diabetes type 1/2	

Women only: (please circle) Are you pregnant? Think you may be pregnant? Nursing? Taking oral contraceptives?

Reviewed with Patient:

Patient signature: _____ Date: _____
Staff signature: _____ Date: _____
Patient signature: _____ Date: _____
Staff signature: _____ Date: _____
Patient signature: _____ Date: _____
Staff signature: _____ Date: _____
Patient signature: _____ Date: _____
Staff signature: _____ Date: _____