

Today's Date:	Northwest Health Care Provider:
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Patient Information (Please Print)

<input type="checkbox"/> Mr.	<input type="checkbox"/> Dr.	Last Name:	First Name:	Middle:	Suffix:	
<input type="checkbox"/> Miss	<input type="checkbox"/> Ms.				<input type="checkbox"/> Jr.	
<input type="checkbox"/> Mrs.					<input type="checkbox"/> Sr.	
					<input type="checkbox"/> Other	
Former Name:		Nickname:	SS#:	Birthdate: / /	Sex Assigned at Birth: <input type="checkbox"/> M <input type="checkbox"/> F	
Home Street Address:		City:	State:	Zip Code:	Country:	County:
Billing Street Address (if different):		City:	State:	Zip Code:	Country:	County:
Home Phone:		Work Phone:		Cell Phone:		

Email Address:

May we email or text appointment reminders and short surveys? Email Text Message

Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> More than One Race <input type="checkbox"/> Refused to Report	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Japanese <input type="checkbox"/> Italian <input type="checkbox"/> Sudanese <input type="checkbox"/> Burmese <input type="checkbox"/> Tigrinya <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Other	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Report	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Female-to-Male (FTM) <i>Transgender Male</i> <input type="checkbox"/> Male-to-Female (MTF) <i>Transgender Female</i> <input type="checkbox"/> Other <input type="checkbox"/> Choose Not to Disclose
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Sexual Orientation:	Contact Preference:	Marital Status:	Student Status:	Veteran:
<input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Lesbian, Gay or Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Something Else <input type="checkbox"/> Choose Not to Disclose	<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Confidential <input type="checkbox"/> Don't Call Home <input type="checkbox"/> Don't Call Work <input type="checkbox"/> Don't Leave Message <input type="checkbox"/> Okay to Leave Message	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Life Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Declined to Specify	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student	<input type="checkbox"/> Yes <input type="checkbox"/> No

PERSON RESPONSIBLE FOR BILL

Last Name:	First Name:	Middle Name:	Previous Last Name:	Nickname:		
SS#:	Birthdate: / /	Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Life Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Other				
Street Address:		City:	State:	Zip Code:	Country:	County:
Home Phone:		Work Phone:		Cell Phone:		



MEDICAL



DENTAL



COUNSELING



PHARMACY

A 340B DRUG DISCOUNT PROVIDER

INSURANCE INFORMATION

Primary Insurance: Medicare Medicaid BCBS United Healthcare Other _____

Name of Insured:	Plan Number:	Policy Number:	Group Name:	Group Number:
Insurance Company Street Address:	City:		State:	Zip Code:
Effective Date: / /		Expiration Date: / /		
Patient Signature:			Today's Date:	

Secondary Insurance: Medicare Medicaid BCBS United Healthcare Other _____

Name of Insured:	Plan Number:	Policy Number:	Group Name:	Group Number:
Insurance Company Street Address:	City:		State:	Zip Code:
Effective Date: / /		Expiration Date: / /		

How Did You Hear About Us (Please Select All that Apply):

Billboard Community Event Friend/Family Newspaper Radio
 Social Media TV Commercial On Premise Signage

EMPLOYER INFORMATION

Employer Name:

Employer Street Address:	City:	State:	Zip Code:	Country:	County:
Occupation:	Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Active Duty <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed <input type="checkbox"/> Unknown	Work Phone:	Retirement Date: / /		

EMERGENCY CONTACT / NEXT OF KIN

Last Name:	First Name:	Relationship:	Phone Number:
Street Address:		City:	State: Zip Code:

HOUSING & WORKER STATUS

Homeless Status: <input type="checkbox"/> Doubling Up <input type="checkbox"/> Not Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional	Migrant Worker Status: <input type="checkbox"/> Migrant Worker <input type="checkbox"/> Not a Farm Worker <input type="checkbox"/> Seasonal Worker
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MEDICAL



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PHARMACY

A 340B DRUG DISCOUNT PROVIDER

INCOME TABLE				
Family Size	Income	Income	Income	Income
1	<input type="checkbox"/> \$0-\$12,140	<input type="checkbox"/> \$12,141-\$18,210	<input type="checkbox"/> \$18,211-\$24,280	<input type="checkbox"/> Over \$24,281
2	<input type="checkbox"/> \$0-\$16,460	<input type="checkbox"/> \$16,461-\$24,690	<input type="checkbox"/> \$24,691-\$32,920	<input type="checkbox"/> Over \$32,921
3	<input type="checkbox"/> \$0-\$20,780	<input type="checkbox"/> \$20,781-\$31,170	<input type="checkbox"/> \$31,171-41,560	<input type="checkbox"/> Over \$41,561
4	<input type="checkbox"/> \$0-\$25,100	<input type="checkbox"/> \$25,101-37,650	<input type="checkbox"/> \$37,651-\$50,200	<input type="checkbox"/> Over \$50,201
5	<input type="checkbox"/> \$0-\$29,420	<input type="checkbox"/> \$29,421-\$44,130	<input type="checkbox"/> \$44,131-\$58,840	<input type="checkbox"/> Over \$58,841
6	<input type="checkbox"/> \$0-\$33,740	<input type="checkbox"/> \$33,741-\$50,610	<input type="checkbox"/> \$50,611-\$67,480	<input type="checkbox"/> Over \$67,481
7	<input type="checkbox"/> \$0-\$38,060	<input type="checkbox"/> \$38,061-\$57,090	<input type="checkbox"/> \$57,091-76,120	<input type="checkbox"/> Over \$76,121
8	<input type="checkbox"/> \$0-\$42,380	<input type="checkbox"/> \$42,381-63,570	<input type="checkbox"/> \$63,571-84,760	<input type="checkbox"/> Over \$84,761

READ AND SIGN THIS SECTION

1. I, the patient:

- Allow my health care provider to give me the treatment I need. This care may include but is not limited to:
 - Radiology to diagnose a problem, tests which may look for contagious diseases such as Hepatitis and HIV/AIDS, taking samples of body fluids or body tissue, and giving medicine, immunizations and vaccines.
- Allow my provider to treat me in emergencies if it may save my life or health.
- Agree that my care at NHS emphasizes care coordination and communication into what we, as a team, deem best for me.
- Allow Northwest Health Services, Inc. (NHS) to release any of my health information to process my claims.
- Allow payment for my treatment to be given to NHS.
- Agree that NHS will file and complete the steps to collect my insurance payment.
- Agree that if my insurance doesn't pay for my care, I am in charge of paying for my treatment.
- Agree that NHS must have a contract with my insurance. If there is no contract, I am in charge of paying for my treatment.

All fees are due when you get your treatment, unless you make other plans before your visit.

Sign: _____ Date: _____

IF YOU ARE A PARENT OR LEGAL GUARDIAN OF A MINOR, READ AND SIGN THIS SECTION
 CONSENT FOR TREATMENT OF A MINOR

2. I agree that:

- I have the legal responsibility for this patient.
- I have the legal right to direct the medical treatment of this patient.
- By signing the consent includes this and later office visits.
- This health record may be given to other providers to treat this minor as needed.

Sign: _____ Date: _____



A 340B DRUG DISCOUNT PROVIDER

IF YOU ARE A MEDICARE PATIENT, READ AND SIGN THIS SECTION
LIFETIME CONSENT FORM

3. I request payment of Medicare Benefits be made to NHS on my behalf. I allow anyone who has my health record to release it to Health Care Financing Administration and its agents:

Sign: _____ Date: _____

READ AND SIGN THIS SECTION REGARDING WORKER COMPENSATION

4. I agree to report any accident or work related injuries to ensure processing of my insurance or Worker's Compensation to the appropriate responsible company.

Sign: _____ Date: _____

Please ask a Patient Access Assistant at the front desk for Worker's Compensation forms when needed.



MEDICAL



DENTAL



COUNSELING



PHARMACY

A 340B DRUG DISCOUNT PROVIDER

WHO CAN HAVE YOUR HEALTH INFORMATION?

Please fill out this form. It will tell us which family members and friends have your permission to have your health information.

Patient Name:		Date of Birth:	
ABOUT THIS FORM:			
<ul style="list-style-type: none"> This form lets those listed below have information about your medical care or payment. This form informs those listed below or a disaster relief organization of your location, health or death. 			
THESE PEOPLE CAN HAVE MY HEALTH INFORMATION:			
1. Name:		Relationship to you:	
Phone Number:		Street Address:	
City:		State:	Zip Code:
Mark all that you approve: <input type="checkbox"/> My Health <input type="checkbox"/> Lab Tests <input type="checkbox"/> HIV Records <input type="checkbox"/> My Treatment <input type="checkbox"/> Other _____ <input type="checkbox"/> Behavioral Health Records <input type="checkbox"/> Mental Health Assessment <input type="checkbox"/> Progress Notes			
2. Name:		Relationship to you:	
Phone Number:		Street Address:	
City:		State:	Zip Code:
Mark all that you approve: <input type="checkbox"/> My Health <input type="checkbox"/> Lab Tests <input type="checkbox"/> HIV Records <input type="checkbox"/> My Treatment <input type="checkbox"/> Other _____ <input type="checkbox"/> Behavioral Health Records <input type="checkbox"/> Mental Health Assessment <input type="checkbox"/> Progress Notes			
3. Name:		Relationship to you:	
Phone Number:		Street Address:	
City:		State:	Zip Code:
Mark all that you approve: <input type="checkbox"/> My Health <input type="checkbox"/> Lab Tests <input type="checkbox"/> HIV Records <input type="checkbox"/> My Treatment <input type="checkbox"/> Other _____ <input type="checkbox"/> Behavioral Health Records <input type="checkbox"/> Mental Health Assessment <input type="checkbox"/> Progress Notes			
PLEASE SIGN HERE:			
By signing below, I allow Northwest Health Services to talk about or release my health information with the people listed above.			
Patient/Guardian Signature:		Today's Date	
Your permission expires in one year unless cancelled in writing.			



By signing below, I acknowledge that I have received a Notice of Privacy Practices from Northwest Health Services.

Patient Signature:		Date:
Print Name:		
Signature of parent or patient's representative (if it applies):		
Please describe your legal right to act on behalf of the patient:		

COMPLAINTS:

If you believe your privacy rights have been violated , you may file a complaint with us. All complaints must be given in writing on the form provided by NHS. To obtain a form, contact NHS or call the Director Quality Improvement at (816) 271-8227. You also may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. **You will not be penalized for filing a complaint.**

