

*Please fill out **ALL** boxes. If you would like to fill out the form in a private area, or would like assistance filling out the form, please inform someone at the front desk*

PATIENT INFORMATION	LEGAL NAME			LAST NAME: FIRST NAME MI		DATE OF BIRTH:	SOCIAL SECURITY #:
	PREFERRED NAME			LAST NAME FIRST NAME		Preferred Pronouns: ☐ She/her ☐ He/him ☐ They/Them ☐ Ze/Hir ☐ Other _____	
	ADDRESS		APT #	CITY		STATE	ZIP
	HOME PHONE #:		CELL PHONE #:		E-MAIL ADDRESS:		
	PATIENT ADVOCATE (SUPPORT WITH MEDICAL DECISIONS & CARE)			RELATIONSHIP:		PHONE #:	
	EMERGENCY CONTACT (If different then patient advocate)			RELATIONSHIP:		PHONE #:	
	MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		EMPLOYMENT: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired		Are you a STUDENT: ☐ Full Time ☐ Not a Student ☐ Part Time		Preferred Contact Method: ☐ Phone ☐ Text Message ☐ Mail ☐ E-Mail ☐ No Preference
	RACE: ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ White ☐ Pacific Islander ☐ Native Hawaiian ☐ More than one race ☐ Choose not to disclose		ETHNICITY: Are you Hispanic? ☐ Yes ☐ No ☐ Choose not to disclose		LANGUAGE: ☐ English ☐ Spanish ☐ Other: _____		Are you a veteran of the U.S. Armed Forces? ☐ Yes ☐ No
	Where did you stay last night? (Please select <u>one</u> response): ☐ Room/apartment/house that you own or rent ☐ Street/car/park/etc. ☐ Foster Care or Group Home ☐ Permanent Supportive Housing ☐ Halfway House ☐ Shelter ☐ In a friend or family members room/apartment/house ☐ Substance Abuse Treatment Facility ☐ Jail/prison/juvenile detention center ☐ Other: _____					Are you currently homeless? ☐ Yes ☐ No Do you live in public housing? ☐ Yes ☐ No	
	Do you have an advance directive (living will)? ☐ Yes ☐ No			If no, are you interested in learning more? ☐ Yes ☐ No			
	As a federally funded facility we are required to report data on household size and income.		Number of People Living in Household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10+		Household Income (Include all family members): ☐ Weekly ☐ Bi-Weekly \$ _____ ☐ Monthly ☐ Yearly		
	What is your current gender identity: ☐ Male ☐ Female ☐ Genderqueer ☐ Male-to-Female (MTF)/Transgender Female ☐ Female-to-Male (FTM)/Transgender Male ☐ Choose not to disclose ☐ Other: _____			What was your gender at birth: ☐ Male ☐ Female		Sexual Orientation: ☐ Straight/ heterosexual ☐ Bisexual ☐ Gay/Lesbian ☐ Something else ☐ Choose not to disclose	
How did you hear about us? ☐ Self-Referred ☐ Friend ☐ Internet ☐ Carson Valley ☐ CCC#2 ☐ CCC#4 ☐ CHANCES ☐ Coleman Hall ☐ FIR ☐ Gaudenzia ☐ Interim House Inc. ☐ Interim House West ☐ Kintock Group ☐ Nationalities Service Center ☐ Other: _____							

If you have your insurance card please give it to the front desk to make a copy. If you do not please complete the below sections		
Primary Insurance:		MA # (if applicable)
Policy Holder Name: _____ ☐ self ☐ mother ☐ father ☐ spouse ☐ other: _____		DOB Social Security #
Secondary Insurance:		
Policy Holder Name: _____ ☐ self ☐ mother ☐ father ☐ spouse ☐ other: _____		DOB Social Security #

PATIENT NAME & DATE OF BIRTH			
LAST NAME	FIRST NAME	MI	DATE OF BIRTH
I hereby give my permission to the staff of the PHMC Health Network to conduct evaluation and intervention services, as necessary, to assist in treatment of mental health and/or substance abuse disorders. The criterion for admission, intervention, treatment completion, and discharge has been fully explained to me by the interviewing medical provider. I understand that with the help of my medical provider I will develop a treatment plan/contract, which will be the basis of my participating in and receiving services, while a patient of the PHMC Health Network. I understand that midlevel providers such as Physician Assistants and Certified Registered Nurse Practitioners may be involved in my treatment. I voluntarily request family planning, medical or behavioral health services through the agency and request that counseling, laboratory tests, examination, treatment or contraception be provided to me or my child. If I am under 18 years old, I understand that family planning services are free of charge. I understand that I will have the opportunity to have all my questions answered. I understand that my signature applies to the eligibility information and general statement. I request payment of authorized Medicare or insurance benefits be made on my behalf to the PHMC Health Network for any services furnished to me by that medical provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or other insurance carrier and their agents any information necessary to determine benefits or the benefits payable for related services. I understand that I am responsible for the payment of my treatment and care, and that I am required to provide the most correct and updated insurance information. I will be responsible for any charges incurred if the information I provide is not correct or updated. I understand that I am responsible for the payment of co-payments, co-insurance, deductibles, and all other procedures or treatment not covered by my insurance. I understand that payment is due at the time of the service, payable by cash, check, or credit/debit card. I hereby authorize that the PHMC Health Network may test me for HIV antibodies, unless I specify otherwise. I am aware that positive tests for sexually transmitted or other communicable diseases will be reported to public health agencies as required by law. I consent to the use and disclosure of my personal health information as outlined in the Notice of Privacy Practices for treatment, payment and operations. I understand that I have the right to revoke this consent at any time in writing, except to the extent that the PHMC Health Network has previously used or disclosed my protected health information in reliance with this consent.			
PATIENT CONSENT & ACKNOWLEDGMENT			
My signature and initials on this form certifies that I have read, understand, and agree to the provisions of this consent for services; I acknowledge that I have received a copy of the Notice of Privacy Practices and Patient Bill of Rights.			
SIGNATURE OF PATIENT / LEGAL GUARDIAN / PATIENT REPRESENTATIVE			INITIALS
RELATIONSHIP OF PATIENT / LEGAL GUARDIAN / PATIENT REPRESENTATIVE ☐ SELF ☐ OTHER:			DATE
INTERPRETER/TRANSLATOR			
I have accurately and completely, read and translated the above document in the patient's or patient's legal guardian's or patient's representative's primary language. The patient understood all of the terms and conditions and acknowledged his/her agreement and consent thereto by signing the document in my presence.			
SIGNATURE OF INTERPRETER/TRANSLATOR			INITIALS
NAME OF INTERPRETER/TRANSLATOR			DATE



NOTICE OF PRIVACY PRACTICES

This notice describes how your protected health information may be used and disclosed and how you can obtain access to your protected health information. Please review it carefully.

I. Introduction

This Notice describes the privacy practices of the Public Health Management Corporation (PHMC). We at Public Health Management Corporation are required by law to maintain the privacy of your protected health information and to provide you with this Notice describing our privacy practices. Protecting the privacy and confidentiality of information about our clients is very important to Public Health Management Corporation. Accordingly, we strive to comply with each of the following practices in everything we do.

Protected Health Information ("PHI") means individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that is created or received by PHMC and that relates to the past, present, or future physical or mental health condition of a individual; the provision of health care services to an individual; or the past, present, or future payment for the provision of health care services to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

II. How we may use and disclose Protected Health Information - Treatment, Payment, Operations and Services Provided

We are permitted or required to use and/or disclose your health information for various purposes. The following categories describe different ways that we may use and/or disclose PHI. However, except in an emergency or other special circumstance, we will ask you to sign an authorization, as required by Pennsylvania Law, so that we may use and /or disclose your PHI for the purposes described below:

A. Treatment:

With your consent, we may use and/or disclose your PHI in order to ensure that you receive proper and needed health care services. For example, we may disclose your health information to another health care provider involved in your care, or to whom you are being referred for additional health related services. In addition, we may contact you to schedule appointments or provide you with information about other treatment alternatives. We may also disclose PHI to other providers (e.g. social workers, therapists, nurses, and other healthcare/service providers).

B. Payment:

We may use and/or disclose your PHI in order to obtain payment for the treatment and/or services we provided to you. For example, to request payment from your health insurer or to receive funding for the treatment and/ or services provided to you by PHMC.

C. Operations:

We may use and/or disclose your PHI for our internal operations. Operations are defined as those activities that are necessary to run our offices, maintain licensure, accreditation, obtain funding and to make sure that our patients receive quality care and/or services. For example, we may use your PHI to review the quality of treatment/services provided to you, and/or treatment and services coordinated for you.

D. Business Associates/Services/Treatment Providers:

Certain aspects and components of the services PHMC offers are provided through contracts with external providers and/or organizations. An example of an external providers and/or organization is an entity that has been contracted by PHMC to provide you with needed treatment and/or services.

1. Health Information Exchange:

- PHMC participates with one or more secure health information organization networks (each, an "HIO"), including an HIO called "HealthShare Exchange of Southeastern Pennsylvania, Inc., ("HSX"), which makes it possible for PHMC to share your Health Information electronically through a secure connected network.
- PHMC may share or disclose your Health Information to HSX and other secure HIOs, including HIOs contracted with the Commonwealth of Pennsylvania, and even HIOs in other states.
- Other health care providers, including physicians, hospitals and other health care facilities, that are also connected to the same HIO network as PHMC can access your Health Information for treatment, payment and other authorized purposes, to the extent permitted by law.
- You have the right to "opt-out" or decline to participate in having PHMC share your Health Information through networked HIOs.
- If you choose to opt-out of data-sharing through HIOs, PHMC will no longer share your Health Information through an HIO network, however it will not prevent how your information otherwise is typically accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).

III. Other Uses and Disclosure of Your PHI as required by Law:

We may use and/or disclose your PHI for any purpose required by law. For example, PHMC may be required by federal, state or local law to use or disclose your PHI to respond to a court order or disclose PHI to the proper authorities for law enforcement purposes.

A. Government Oversight Agencies:

We may use and/or disclose your PHI if authorized by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings. For example, the Department of Public Welfare that conducts audits of medical assistance payments for services provided.

B. Prevention of Violence:

If we believe you are a victim or perpetrator of abuse, neglect or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized to receive reports of abuse, neglect or domestic violence.

C. Public Health Activities:

We may use and/or disclose certain PHI for public health initiatives, such as reporting of disease, injury, and death, and for public health investigations. We may also disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.

D. Aversion of a Serious Threat to Public Health or Safety:

We may use and/or disclose PHI about you when necessary to prevent a serious threat to your health and safety or that of the public or another person. Any disclosure however, would only be made to an agency or person able to help prevent the threatened harm.

E. Military Purposes:

We may use and/or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.

F. Worker's Compensation:

We may use and/or disclose your PHI to workers' compensation agencies or similar programs that provide benefits for work related injuries or illnesses sustained at work as required and permitted by law.

G. Secretary of the Department of Health and Human Services:

We will, if required by law release your PHI to the Secretary of the Department of Health and Human Services for enforcement of the Health Insurance Portability and Accountability Act.

IV. Uses and Disclosures Requiring Your Authorization:

Highly Confidential Information

Federal and state laws require special privacy protections for certain highly confidential information about you. This includes PHI:

1. Maintained in psychotherapy notes;
2. Documenting mental health and developmental disabilities services;
3. About drug and alcohol abuse, prevention, treatment and referral;
4. And relating to HIV/AIDS testing, diagnosis or treatment and other sexually transmitted disease

Generally, we must obtain your written authorization to release this type of information. However, there are limited circumstances under the law when this information may be released without your consent. For example, certain sexually transmitted disease must be reported to the Department of Health.

V. Your Rights Regarding Your Protected Health Information

A. Right to Inspect and Copy Your Protected Health Information

You may request to see and receive copies of your medical/treatment/service and billing records. To do so, please submit a written request to the appropriate PHMC office or programs.

B. Right to Request Amendment

You have the right to request that we amend PHI maintain about you. To request an amendment, your request must be made in writing and submitted to our office. You must state in your request why you believe that the PHI is incorrect or incomplete. We are not obligated to make requested amendments, but will give each request careful consideration. If we deny your request, you have a right to give us a short statement to be placed with your PHI or to have your request for amendment attached to your PHI.

C. Right to an accounting of Disclosures:

You have the right to request a record of certain disclosures of your PHI. Your request may cover any disclosure made in the six years prior to the date of your request. However, we are not required to give you a record of disclosure that occurred before April 14, 2003.

D. Right to Request Restrictions:

You have a right to request additional restrictions on PHMC's use and disclosure of your PHI. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. HIPAA does not require us to agree to your request, but we will accommodate reasonable requests when appropriate.

E. Right to Request Confidential Communications:

You have the right to request that we communicate with you about PHI in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. To request confidential communications, you must make your request in writing to our office. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

F. For Further Information/Complaints:

If you desire further information about your privacy rights, our concern is your privacy rights are violated or disagreed with a decision we made about access to your PHI. You may contact our Privacy Officer at:

Privacy Officer
Public Health Management Corporation
Division of Total Quality Management
Center Square East
1500 Market Street
Philadelphia, PA 19102

Additionally, you may also file a written complaint with a Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address.

VI. Effective Date and Duration of this Notice

A. Effective Date

This Notice is effective on April 14, 2003; revised on September 21, 2017

B. The Right to Change this Notice

We may change the term of this Notice at any time. If we revise this Notice, we will post the revise the Notice online at: www.phmc.org. You may also obtain a revised Notice by contacting the Privacy Office

X

X

FEE ASSESSMENT FORM

Please fill out this information in its entirety, which will help us assess your financial situation to see if you are eligible for a discounted sliding fee schedule. Please note that all information collected is confidential, and will not leave this office.

To accurately assess your financial responsibility you must supply proof of income for all working individuals within the household. This can be at least two pay stubs for each working person in the household, last year's household income tax return(s), or a letter from the employer (or coworker if paid under the table) stating weekly pay, unemployment compensation verification, worker's verification, etc.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH			
I am a patient or parent/guardian of a patient who is about to receive health care services at the PHMC Health Network, and declare my household income as follows: <table style="width: 100%; border: none;"> <tr> <td style="vertical-align: top; width: 30%;"> Number of People Living in Household: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 </td> <td style="vertical-align: top; width: 30%;"> Gross Household Income: \$ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly </td> <td style="vertical-align: top; width: 40%;"> Household Sources of Income: ☐ Regular Employment ☐ Under the Table Work ☐ Workers' Compensation ☐ Pension ☐ Welfare ☐ Social Security ☐ Unemployment ☐ Other: _____ </td> </tr> </table> I understand this form satisfies the income verification requirements for this visit only and that I must bring proof of income with me on my next visit for verification purposes at the PHMC Health Network. By signing this form, I am aware that I am providing this information for the sole purpose of fee assessment for the health center's discounted sliding fee schedule. If I do not bring proof of income with me on the next visit, I understand the health center will hold me responsible to pay the full charges for any services provided.				Number of People Living in Household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	Gross Household Income: \$ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	Household Sources of Income: ☐ Regular Employment ☐ Under the Table Work ☐ Workers' Compensation ☐ Pension ☐ Welfare ☐ Social Security ☐ Unemployment ☐ Other: _____
Number of People Living in Household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	Gross Household Income: \$ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	Household Sources of Income: ☐ Regular Employment ☐ Under the Table Work ☐ Workers' Compensation ☐ Pension ☐ Welfare ☐ Social Security ☐ Unemployment ☐ Other: _____				
SIGNATURE OF PATIENT/LEGAL GUARDIAN			DATE			
PRINT NAME OF PATIENT/LEGAL GUARDIAN						

PATIENT RIGHTS AND RESPONSIBILITIES

ISSUES OF CARE

The **PHMC Health Network** is committed to your participation in care decisions. As a Patient, you have the right to ask questions and receive answers regarding the clinical care recommended by any of our Health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask for any clarification you need.

Patient Rights

- **You have the right to respectful care** given by competent personnel, which considers your personal value and belief systems and which places high value on your comfort and dignity.
- **You have the right to know which clinic policies, rules, and regulations** apply to you as a patient.
- **You have the right to expect emergency procedures** to be implemented without unnecessary delay.
- **You have the right to good quality care and high professional standards** that are continually maintained and reviewed.
- **You have the right to expect good management techniques** to be applied within this health care facility, which is respectful of your time and avoids your personal discomfort.
- **You have the right to medical and nursing services** without discrimination based upon race, color, religion, gender, sexual preference, handicap, nation origin, or source of payment.
- **You have the right to appropriate assessment and management of pain**
- **You have the right, in collaboration with your care provider, to make decisions** involving your health care. This right applies to the family and/or guardian of neonates, children, and adolescents.
- **While this health care facility recognizes your right to participate in your care and treatment** to the fullest extent possible, there are some instances you may not be able to do so. In these situations (e.g., if you have been decided incompetent in accordance with law, are found by your care provider to be medically incapable of understanding the proposed treatment of procedure, are unable to communicate your wishes regarding treatment, or are an unemancipated minor) your rights are to be exercised to the extent permitted by law, by your designated representative or other legally designated person.
- **You have the right to make decisions** regarding the withholding of resuscitative services or the foregoing of or the withdrawal of life-sustaining treatment within the limits of the law.
- **You have right, upon request, to be given the names** and professional status of all health care personnel, including medical students, or other trainees, having direct contact with you while being treated in our clinic.
- **You have the right to every consideration of privacy** concerning your medical care program. Case discussion, consultation, examination, and treatment are considered confidential and should be conducted discreetly giving reasonable visual and auditory privacy when possible. This includes the right, if requested, to have someone present while physical examinations, treatments, or procedures are being performed, as long as they do not interfere with diagnostic procedures or treatment.
- **You have the right to receive care in a safe setting, and be free from all forms of abuse and harassment.**
- **You have the right to have all information**, including records, pertaining to your medical care treated as confidential except as otherwise provided by law or third-party contractual arrangement.
- **You have the right to be free from restraint and seclusion not medically necessary or used as a means of coercion, discipline, convenience or retaliation by staff.**

- **You have the right to have your medical record** read only by individuals directly involved in your care, by individual monitoring the quality of your care, or by individuals authorized by law or regulation. You or your designated/legal representative, upon request, will have access to all information contained in your medical records, unless access is specifically restricted by your care provider for medical reasons.
- **You have the right to be communicated with** in a manner that is clear, concise and understandable. If you do not speak English, you should have access, where possible, to an interpreter.
- **You have the right to full information** in layman's terms, concerning diagnosis, treatment, and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable that such information be given to you, the information shall be given on your behalf to your designated/legal representative.
- Except for emergencies, your care provider must obtain the necessary **informed consent** prior to the start of any procedure or treatment, or both.
- **You have the right to access protective services.**
- **You have the right to not be involved** in any experimental, research, donor program, or educational activities unless you have, or your designated/legal representative has, given informed consent prior to the actual participation in such a program. You or your designated/legal representative may, at any time, refuse to continue in any such program to which informed consent has previously been given.
- **You have the right to accept medical care or to refuse** any drugs, treatment, or procedure offered by the Clinic, to the extent permitted by law, and a care provider shall inform you of the medical consequences of such refusal.
- **You have the right to participate in the consideration of ethical issues** surrounding your care within the framework established by this organization to consider such issues.
- **You have the right to formulate an "advance directive,"** or to appoint someone to make health care decisions on your behalf. These decisions will be honored by this facility and its health care professionals within the limits of the law and this organization's mission, values and philosophy. If applicable, you are responsible for providing a copy of your "advance directive" to the facility or caregiver.
- **You are not required to have or complete an "advance directive"** in order to receive care and treatment in this facility.
- **You have the right to assistance in obtaining consultation** with another physician at your request and expense.
- **You have the right to full information and counseling** on the availability of known **financial resources** for our health care, if appropriate.
- **You have the right to expect** that your care provider will provide information on **continuing health care requirements or instructions** after your appointment.
- **You cannot be denied the right of access** to an individual or agency who is authorized to act on your behalf to assert or protect the rights set out in this section.
- **Information regarding your rights** as a patient will be made available to you upon request and will be easily visible to you on each visit to the clinic.
- **You have the right, without recrimination, to voice complaints** regarding your care, to have those complaints reviewed, and, when possible, resolved.
- If you or a family member thinks that a complaint or grievance remains unresolved through the PHMC Health Network process, you also have the right to contact:

Division of Acute and Ambulatory Care

PA Department of Health
P.O. Box 90
Health and Welfare Building
Harrisburg, PA 17180-0900
1-800-254-5164
OR

Department of Health Services Center for Medicare and Medicaid Services (CMS)

1-800-MEDICARE

Patient Responsibilities

- **To the extent possible, you or your designee has a responsibility to be truthful** and to express your concerns clearly to your health providers.
- **You have a responsibility to provide a complete medical history**, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.
- **You have the responsibility to request information or clarification about your health** status or treatment when you do not fully understand what has been described.
- Once you and your health providers agree upon your healthcare goals, **you have a responsibility to follow the treatment plan and notify your care provider of any concerns or potential needs for modification of the treatment plan.** You also have a responsibility to disclose whether previously agreed-upon treatments are being followed and to indicate when you would like to reconsider the treatment plan.
- **You have the responsibility to participate as fully as possible in your care**, including attending appointments as is feasible, and complying with your identified treatment plan.
- **You have the responsibility to respect fellow patients and office staff**, in any office communications or interactions.