LEGACY COMMUNITY HEALTH

ADULT CLIENT INTAKE FORM

Date: ____________________ **Chart #:** _________________________ **Age:** ________________________

Legacy Community Health is a Community Health Center and all information requested is for statistical purposes. All information is strictly confidential to the full extent permitted by law. No identifying information will be released without your consent. The information requested allows Legacy to evaluate each client for eligibility for our programs; therefore, we request you complete this document in its entirety.

NAME	PREFERRED NAME (IF APPLICABLE)	MOTHER'S MAIDEN NAME

ADDRESS	CITY/STATE	ZIP CODE	COUNTY

MAIN PHONE NUMBER	OTHER PHONE NUMBER	EMAIL ADDRESS	DATE OF BIRTH

PREFERRED METHOD(S) OF CONTACT		
Telephone: ○ Yes ○ No Okay to leave message: ○ Yes ○ No	Mail: ○ Yes ○ No	☐ No Contact

MARITAL STATUS	SEXUAL ORIENTATION
○ Single ○ Married ○ Living with Domestic Partner ○ Divorced ○ Other	○ Heterosexual ○ Homosexual ○ Bisexual

GENDER	TRANSGENDER	SOCIAL SECURITY	BIRTH STATE/COUNTRY	DRIVERS'S LICENSE
○ Male ○ Female	○ Yes ○ No			

PREFERRED LANGUAGE	RACE		
○ English	○ White	○ Black/African American	○ Asian
○ Spanish	○ Multiracial	○ Pacific Islander	○ Hawaiian
○ Other/Otro	○ Other	○ American Indian/Alaska Native	○ Unknown/Decline to State

ETHNICITY	HOMELESS	AGRICULTURE WORKER	U.S. MILITARY VETERAN
○ Hispanic ○ Non-Hispanic	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

FAMILY SIZE (NUMBER OF PERSONS LIVING IN YOUR HOME)	TOTAL FAMILY HOUSEHOLD INCOME

Please provide your emergency contact information below.

NAME	RELATIONSHIP	PHONE NUMBER	ADDRESS
Does this person know that you are a patient of Legacy Community Health? ○ Yes ○ No			

Primary Caregiver
(Person responsible for providing day-to-day care for the patient. Appropriate documentation must be provided.)

○ N/A, I do not have a primary caregiver	NAME	RELATIONSHIP	PHONE NUMBER
○ Same as emergency contact			

Legal Guardian
(Court appointed person to make healthcare decisions in place of patient. Appropriate documentation must be provided.)

○ N/A, I do not have a Legal Guardian	NAME	RELATIONSHIP	PHONE NUMBER
○ Same as emergency contact			

Name: ______________________

Healthcare Proxy
(Person patient appoints to make healthcare decisions in their place. Appropriate documentation must be provided.)

◯ N/A, I do not have a Healthcare Proxy	Name	Relationship	Phone Number
◯ Same as emergency contact			

Medical Information

NAME OF PRIMARY CARE PROVIDER	ADDRESS	PHONE NUMBER
NAME OF PREFERRED PHARMACY	**ADDRESS**	**PHONE NUMBER**

DO YOU HAVE ANY HEALTHCARE DIRECTIVES?
◯ Yes ◯ No ☐ Do Not Resuscitate ☐ Medical Power of Attorney ☐ Living Will

MATERNITY PATIENTS ONLY	
☐ N/A	For your current pregnancy, in what month of your pregnancy did you first receive care? ______________
	Did you receive this care from Legacy Community Health? ◯ Yes ◯ No

Complete the insurance questions below.

DO YOU OR ANYONE IN YOUR HOUSEHOLD HAVE MEDICAID, MEDICARE, CHIP, V.A., OR OTHER INSURANCE COVERAGE?
◯ Yes ◯ No If yes, who?

WHAT TYPE OF HEALTH INSURANCE DO YOU HAVE?
◯ None / Self Pay ◯ Military ◯ Medicare Plan ◯ Medicaid Plan ◯ Private Insurance
Plan Number: ______________ Group Number: ______________
Private Insurance Company: ______________
PCP Provider if HMO Policy: ______________

INSURED/POLICY HOLDER'S INFORMATION	INSURED EMPLOYER'S INFORMATION
Name: ______________	Name: ______________
Date of Birth: ______________	Address: ______________
Social Security #: ______________	______________
	Phone: ______________

Marketing

HOW DID YOU LEARN ABOUT OUR SERVICES?
◯ Friend/ Relative ◯ In Print ◯ On Radio/TV ◯ Internet ◯ Referral ◯ Community Event ◯ Other

By signing this form, I attest that all the statements I have made, including my answers to all questions are true and correct to the best of my knowledge and belief. I agree to give the eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment. Should my income or number of people in my family change, I will tell the eligibility staff.

______________________________ ______________
Signature of Client or Parent /Guardian or Power of Attorney Date

______________________________ ______________
Signature of Person Who Helped Complete this Form Date

LEGACY
COMMUNITY HEALTH

ADULT CONSENT & ACKNOWLEDGMENT FOR SERVICES

Name: ________________________________

Completion of this consent is necessary to offer services to a patient. Some items may not apply to your current situation; however, in order to provide comprehensive care during this visit and future visits we request that you complete this consent in its entirety. You have the privilege of revoking this consent, by providing written notice, at any time.

CONSENT FOR TESTING AND TREATMENT

By initialing, I hereby grant permission to Legacy Community Health to perform such tests, treatments and procedures as ordered by the medical staff for diagnostic and/or therapeutic purposes, including, but not limited to, STD testing including but not limited to HIV. As part of the testing and treatment I may receive disease-specific prevention, education, and risk-reduction services. Legacy Community Health is required by state law to report my name, address, treatment and other information to the City of Houston Department of Health & Human Services for known persons who test positive for TB, HIV/AIDS, and syphilis. Persons who test positive may be contacted by a Disease Intervention Specialist (DIS) to ensure they have been successfully treated and that sex partners who may be at risk for the disease have been notified about their potential risk.

_____(Initials)

ACKNOWLEDGMENT OF RECEIPT

By initialing, I acknowledge that Legacy Community Health has provided me with its: Notice of Privacy Practices, which explains how my health information will be handled in various situations; Client Rights and Responsibilities, which I agree to abide by; Grievance Policy, for filing complaints; and E-Prescribing Information Sheet.

_____(Initials)

FINANCIAL RESPONSIBILITY

By initialing below, I understand that if I qualify for services through a grant funded program such as Ryan White or the Department of State Health Services Family Planning (Title X) these resources are payers of last resort. Meaning that, if I currently or in the future have Medicare, Medicaid and/or third party insurance, I may not be eligible for services under these grants. Therefore, I agree to immediately report any changes in my financial status and/or insurance coverage to the Eligibility Specialist. If such changes have not been appropriately reported and if those changes in my status result in my ineligibility for services under a grant funded program at Legacy Community Health, I understand that I am fully responsible for the cost of services delivered by Legacy Community Health.

_____(Initials)

MEDICAID / MEDICARE / THIRD PARTY INSURANCE

By initialing below, if I become eligible for Medicaid, Medicare and/or third party insurance while a client of Legacy Community Health, I authorize Legacy Community Health to furnish Medicaid and/or Medicare and/or a third party insurer all of the necessary medical information including my HIV status to process my claim.

_____(Initials)

By initialing, I hereby assign to Legacy Community Health all payments from Medicaid, Medicare and/or any other third party insurer for medical services provided. I understand that I am responsible for the cost of services delivered that are not covered by my insurance. I also understand that I may be responsible for my co-pay to be paid prior to me being seen by a health care practitioner.

_____(Initials)

Consent for Communication with Delegated Individual

By initialing, I authorize Legacy Community Health to communicate with the following individual about my healthcare which may include information about my medical diagnosis, eligibility status and appointments.

______________________	______________________	______________________
First Name	Last Name	Relationship

______(Initials)

Terms of Consent

By signing below, I agree to the terms and information above. I am giving this consent of my own free will. I fully release Legacy Community Health and the Harris County Public Health & Environmental Services, and Ryan White Grant Administration, as well as their Officers, Directors, Board Members, employees, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, claims, litigation, demands, defenses, judgments, suits, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements and expenses of attorney, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services.

I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

____ ______________
Client Name Printed Initials

____ ______________
Signature of Client or Parent / Guardian or Power of Attorney Date

____ ______________
Witness Signature Date

CONSENT AND ACKNOWLEDGEMENT FOR OBTAINING E-PRESCRIBING HISTORY

Patient Name: ______________________________ Date: ______________________

ACKNOWLEDGMENT OF RECEIPT OF E-PRESCRIBING INFORMATION SHEET

By initialing, I acknowledge that Legacy Community Health has provided me with its E-Prescribing Information Sheet, which explains the purpose and details on how my prescriptions and prescription refill history will be handled electronically._______(Initials)

TERMS OF CONSENT

I understand that providing Legacy Community Health with a history of my current and past prescriptions will assist the agency in confirming the safety of my prescriptions and decreasing dangerous interactions with any other medications I may be taking.

☐ I hereby grant Legacy Community Health permission to obtain this medication history electronically from other healthcare organizations, including, but not limited to pharmacies.

☐ I **decline** the option of providing Legacy Community Health with a history of my current and past prescriptions.

By signing below, I agree that I am completing this consent of my own free will to consent as initialed above. I fully release Legacy Community Health, their employees, Board Members, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, claims, litigation, suits, proceedings, of any kind or nature whatsoever resulting from out of my receipt of this service.

I understand that this consent shall remain active until I withdraw my consent in writing at any time.

____ ______________

Client Name Printed Initials

____ ______________

Signature of Client or Parent / Guardian or Power of Attorney Date

____ ______________

Witness Signature Date

LEGACY
COMMUNITY HEALTH

CONSENT FOR REVIEW OF RECORDS FOR RESEARCH

Legacy Community Health participates in research studies, which involve proven or experimental treatments. The staff of Legacy would like to review your records to determine if you are eligible to participate in current or future studies.

By signing this form, you are only indicating that you are willing to share the information located in your patient records with the Legacy research staff. The sole purpose of this information is to determine if you qualify for a research study. **You are not agreeing to be in a research study by signing this form**.

This consent may be revoked at any time, except to the extent that action may already have been taken in reliance on it.

Client Name Printed ______________________ Initials __________

Signature of Client or Parent / Guardian or Power of Attorney ______________________ Date __________

Witness Signature ______________________ Date __________