BAY MILLS HEALTH CENTER
PATIENT CONSENT FORM

Chart # ______________________

DEMOGRAPHICS

Patient Name: ____
(First) (Middle Int.) (Last)

Maiden Name: ______________________ **DOB:** ____/____/____ **Age:** __________ **Gender:** ________________

Marital Status: ◯ Married ◯ Widowed ◯ Divorced or Separated ◯ Never Married or Single

Mailing Address: ______________________________ City/State/Zip: ______________________

SS#: ____________________ **Phone:** (H) ______________ (Cell): ________________ **Date moved to area:** __________

Access to internet: YES NO Email Address: ________________________ Method to contact: ______________

Ok to leave message: YES NO **Are you a Veteran:** YES NO If Yes, which branch: ______________________

Vietnam Connected: YES NO Entry/Exit Date: ______________/______________

Migrant worker: YES NO **Seasonal Agricultural Worker:** YES NO

Are you homeless: YES NO If yes, where are you residing? ______________________________
(With Immediate family, Homeless Shelter, Doubling up, Street, Unknown, or Other)

Race: ◯ Asian ◯ Black or African American ◯ Caucasian ◯ American Indian or Alaska Native ◯ Native Hawaiian or Pacific Islander ◯ Decline

Native American: (Federally recognized tribe) ______________________________________(proof required)

Ethnicity: ◯ Hispanic/Latino ◯ Non-Hispanic/Latino ◯ Unknown ◯ Decline

Primary Language: ◯ English ◯ Other: ________________________ **Interpreter required:** YES NO

Employer: ____

Household Income: All information is confidential, it is required to collect such information for federal funding: Fill in the dot that shows the income range for your household size. If more than 5 person household write in the number and income. Round answer to nearest dollar.

Household of **1**	◯ $0-12,490	◯ $12,491 - 18,735	◯ $18,736 - 24,980	◯ $24,981+	If more than 5 in household add here.
Household of **2**	◯ $0-16,910	◯ $16,911 – 25,365	◯ $25,366 - 33,820	◯ $33,821+	Household # __________
Household of **3**	◯ $0-21,330	◯ $21,331 – 31,995	◯ $31,996 - 42,660	◯ $42,661+	Income $ __________
Household of **4**	◯ $0–25,750	◯ $25,751 – 38,625	◯ $38,626 - 51,500	◯ $51,501+	
Household of **5**	◯ $0–30,170	◯ $30,171 – 45,255	◯ $45,256 - 60,340	◯ $60,341+	

Emergency Contact: ________________________ Relationship: ______________ Phone: ______________

Parent/Spouse/Nearest Relative/Guardian: ________________________ Relationship: ______________ Phone: ______________

INSURANCE INFORMATION

Do you have current Health Insurance: YES NO **(If No, please see next box about Sliding Fee Program/Purchased Referred Care)**

Primary Insurance Subscriber Name: ______________________ **DOB:** ______________

Secondary Insurance Subscriber Name: ______________________ **DOB:** ______________
(If different from Primary)

Tertiary Insurance Subscriber Name: ______________________ **DOB:** ______________
(If different from Primary & Secondary)

Office staff will photocopy ID and Insurance Cards

SLIDING FEE PROGRAM/ PURCHASED REFERRED CARE

I understand that services performed by BMHC will only be discounted by the Sliding Fee program or Purchased Referred Care as a last resort of payment. I received information on how to apply for the BMHC Sliding Fee Program as an uninsured or under-insured patient.

________**Sliding fee program** application has been provided to me.
(Pt. Init)

________I have declined a copy of the **Sliding fee program** and I am aware it is available to me in the future.
(Pt. Init)

FINANCIAL RESPONSIBILITY

I understand that I remain financially responsible for all charges incurred for services rendered at Bay Mills Health Center (BMHC). BMHC will bill any applicable insurance company for payment of services. It is my responsibility to provide my insurance information at the time of my appointment or any future changes. Any balance remaining is my responsibility and I will make consistent and timely payments until the balance is paid in full.

Person Responsible for payment:______________________________ Relationship:______________________________

PATIENT RIGHTS AND RESPONSIBILITIES

________**PATIENT'S RIGHTS AND RESPONSIBILITIES** have been made available to me and I have read and understand these rights and responsibilities.
(Pt. Init)

________I have declined a copy of the **PATIENT'S RIGHTS AND RESPONSIBILITIES** and I am aware that they are available to me in the future.
(Pt. Init)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Notice of Privacy Practices for BMHC has been made available to me for my review. I understand that I may request a copy of the notice at any time.

Patient / Representative Signature:______________________________ Date:____________________

AUTHORIZING INDIVIDUALS

List individuals you authorize to schedule appointments and access limited financial information to help with payments.

Name: ______________________________ Phone: ____________________ Relationship: ____________________

Name: ______________________________ Phone: ____________________ Relationship: ____________________

AGREEMENT FOR EXAMINATION AND/OR TREATMENT

I hereby voluntarily agree and consent to be examined and treated by my provider at BMHC. I understand I have the right to participate in decisions involving my health care. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by healthcare providers. I understand that there are a certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

CONSENT TO USE INFORMATION

I hereby authorize release of any and all health records relevant to my examination and/or treatment, to a consulting and/or referring provider or agency of continuing care, including but not limited to other practitioners of BMHC staff. I also authorize the release of these records for any payment or quality management related purpose to any insurance carrier, government agency, or unit of any third party payer in any way involved in the payment for all or any part of my health care.

I HAVE READ THIS CONSENT FORM AND I AM FULLY AWARE OF AND AGREE TO THE CONTENTS. *THIS FORM IS VALID FOR ONE YEAR FROM THE DATE OF THE MOST RECENT SIGNATURE.*

______________________________ ______________________________
Insured/Patient/Guardian/Guarantor Witness

______________________________ ______________________________
Date Date