Date: ____________________ Patient ID: ____________

DELHI COMMUNITY HEALTH CENTER
PATIENT INFORMATION FORM: MEDICAL-BHI 2021

Last Name ________________________ First Name ____________________ MI ____ Jr. Sr. III

Mailing Address ____

Address City State Zip

Physical Address ____

Date of Birth ____________ SSN _____ - _____ - _____ E-Mail ______________________

Home Phone # ______________ Cell Phone # ________________ Work Phone # ______________

School ____ Grade ___________________________

Pharmacy ______________________________________

Dentist ____ ☐ Please check if you do not have a Primary Dentist

Consent to receive calls: Yes No Consent to receive texts: Yes No

***Children under 18 years of age must be accompanied by an adult. See below for further instructions.**

Primary Guardian: Last Name ___________________________ First Name ____________________

Address _______________________________ City ____________________ Zip Code __________

Date of Birth ____________ SSN _____ - _____ - _____ E-Mail ______________________

Home Phone # ________________ Cell Phone # ________________ Work Phone # ______________

Secondary Guardian: Last Name _________________________ First Name ____________________

Address _______________________________ City ____________________ Zip Code __________

Date of Birth ____________ SSN _____ - _____ - _____ E-Mail ______________________

Home Phone # ________________ Cell Phone # ________________ Work Phone # ______________

Patient/Policy Holder Insurance Information

Company Name: ____

Policy or Card #: ____

Policy Holder's Last Name: ________________________ First Name: ___________________

Policy Holder Relationship to Patient: ____

Policy Holder's Date of Birth: _____/_____/_____

Policy Holder's SSN#: ______ - ______ - ______

Policy Holder's Address: ____________________ City: ______________ Zip Code: _________

If Medicaid, PCP (Referring Dr.) ____

Delhi Community Health Center is a Federally Qualified Health Center and is required to collect population data.

Are you a veteran of the military? ☐ Yes ☐ No

Sex at Birth: Male Female

Gender ID: Male Female Transgender male to female Gender Queer Transgender female to male Choose not to disclose Other

Sexual Orientation: Lesbian Gay or Homosexual Straight or heterosexual Bisexual Something else Don't know Choose not to disclose

Race *(check one):* ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other

Ethnicity *(check one):* ☐ Hispanic ☐ Non-Hispanic

What is your marital status? *(check one):* ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Housing Status *(check one):* ☐ Homeless ☐ Doubled Up ☐ Street ☐ Transitional ☐ N/A

How many people live in your household? ____________________

Transportation Needs: How are you transported to appointments? ____

Who can we contact in case of emergency?

Last Name: ______________________________ First Name: ______________________________

Address: ______________________________ Phone #: ______________ Relationship to You: ____________

Please ask us about our sliding fee discount program!

Baseline Income Information

Are you receiving any one of the following benefits? (We must have copies of any that are marked yes to be eligible for our sliding fee discount program.)

	YES	NO	If so, how much?
Medical Assistance	☐	☐	______________
State Public Assistance	☐	☐	______________
SSI / SSDI	☐	☐	______________
Social Security	☐	☐	______________
Veterans Retirement/Disability	☐	☐	______________
Workers Compensation	☐	☐	______________
Unemployment	☐	☐	______________

Annual Income in your household

- ☐ $10,000 - 20,000
- ☐ $21,000 - 35,000
- ☐ $36,000 - 40,000
- ☐ $41,000 - 50,000
- ☐ $51,000 +

***The following must be completed on all patients under the age of 18:**

- Are parents: Married/Civil Union _________; Separated ________; Divorced ___________; Living Together __________
- If parents are no longer together, are either of the child's parents remarried: Yes No
- (list any step-parents names): ____
- Does the child live with his/her mother: Yes No If yes, does the child live with her: Full Time Part-Time
- Does the child live with his/her father: Yes No If yes, does the child live with him: Full Time Part-Time
- If the minor child's parents are divorced and/or a custody agreement is in place, please state which parent/legal guardian has domiciliary decision-making authority and custody of the minor child:____________________________
- If the minor child's parents or legal guardians are not married or are legally separated, please provide the court custody order or custody agreement that states who has decision-making authority and custody of the minor child.

Patient Signature: ____

Guardian Signature if patient under 18: ____

Date: ______________________________ Time: ______________________________

Date: ______________ **DELHI COMMUNITY HEALTH CENTER** Pt ID #: ______________

Behavioral Health Services

Intake Form

What is the problem(s) for which you are seeking help? (Reason for Referral)

____

____

____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

Depressed Mood	Anxiety	Anger	Hyperactivity
Alcohol/Substance Use	Sleep Disturbances	Suicidal Thoughts	Homicidal Thoughts
Withdrawn Behavior/ Social Isolation	Acute Reaction to Stress/Trauma	Paranoia	Hallucinations/Delusions
Lack of Motivation	Low Self-Esteem	Over/Under Eating	Grief
Nightmares	Emotional Disturbances	Somatic Symptoms	Obsessive Behaviors
Low Impulse Control	Aggressive Behaviors	Peer Problems	Conduct Problems
Defiance	Lack of Empathy	Running Away	Has unusual Sexual Knowledge
Lying	Stealing	Tantrums	Acting out Sexually
Bed/Day Wetting	Cruelty to Animals		

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? *(check one)* ☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? *(check one)* ☐ Yes ☐ No

Have you ever tried to kill or harm yourself before? *(check one)* ☐ Yes ☐ No

How often do you have these thoughts? ______________________________

When was the last time you had thoughts of dying? ______________________________

Has anything happened recently to make you feel this way? ______________________________

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? ______________

What, if anything could make it better? ______________________________

Have you ever thought about how you would kill yourself? ______________________________

Is the method you would use readily available? ______________________________

Have you planned a time for this? ______________________________

Is there anything that would stop you from killing yourself? ______________________________

Do you feel hopeless and/or worthless? ______________________________

Past Psychiatric History:

Outpatient treatment: ❒ Yes ❒ No If yes, describe when, by whom, and nature of treatment.

Reason, Dates, Treated by Whom: ______________________________

____

____

Psychiatric Hospitalization ❒ Yes ❒ No If yes, describe for what reason, when and where.

Reason, Dates, Hospitalized Where: ______________________________

____

____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for: *(check one)* ❒ Yes ❒ No

Bipolar disorder: ❒ Yes ❒ No Schizophrenia: ❒ Yes ❒ No Depression: ❒ Yes ❒ No

Post-traumatic stress: ❒ Yes ❒ No Anxiety: ❒ Yes ❒ No Alcohol abuse: ❒ Yes ❒ No

Anger: ❒ Yes ❒ No Suicide: ❒ Yes ❒ No Violence: ❒ Yes ❒ No

Substance abuse: ❒ Yes ❒ No

If yes, who had each problem? ______________________________

____

Has any family member been treated with a psychiatric medication? ❒ Yes ❒ No If yes, who was treated, what medications did they take, and how effective was the treatment? ______________________________

____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ❒ Yes ❒ No

If yes, for which substances? ______________________________

If yes, where were you treated and when? ______________________________

How often do you have a drink containing alcohol? ❒ Never ❒ Monthly or less ❒ 2-4 times a month ❒ 2-3 times a week ❒ 4 or more times a week

How many drinks containing alcohol do you have on a typical day? ❒ 1 or 2 ❒ 3 or 4 ❒ 5 or 6 ❒ 7 or more

How often do you have six or more drinks on one occasion? ❒ Never ❒ Monthly or less ❒ 2-4 times a month ❒ 2-3 times a week ❒ 4 or more times a week

Have you ever felt you ought to cut down on your drinking or drug use? ❒ Yes ❒ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No

Have you ever abused prescription medication? ☐ Yes ☐ No If yes, which ones and for how long? ______________

____

Check if you have ever tried the following: *(check one)* ☐ Yes ☐ No If yes, how long and when did you last use?

Methamphetamine ☐ Yes ☐ No ______________

Cocaine ☐ Yes ☐ No ______________

Stimulants (pills) ☐ Yes ☐ No ______________

Heroin ☐ Yes ☐ No ______________

LSD or Hallucinogens ☐ Yes ☐ No ______________

Marijuana ☐ Yes ☐ No ______________

Pain killers (not as prescribed) ☐ Yes ☐ No ______________

Methadone ☐ Yes ☐ No ______________

Tranquilizer/sleeping pills ☐ Yes ☐ No ______________

Alcohol ☐ Yes ☐ No ______________

Ecstasy ☐ Yes ☐ No ______________

Other (please provide information): ______________

Tobacco History:

Have you ever smoked cigarettes? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No How many packs per day on average? __________ How many years? __________

In the past? ☐ Yes ☐ No How many years did you smoke? __________ When did you quit? __________

Have you ever smoked a pipe, cigars, or used chewing tobacco? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No How often per day on average? __________ How many years? __________

In the past? ☐ Yes ☐ No How many years? __________ When did you quit? __________

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No

If yes, you may provide any additional information regarding this trauma: ____________________

Is there anything else that you would like us to know?

Signature: ______________________________ Date/Time: ____________

Guardian Signature (if under age 18): ______________________________ Date/Time: ____________

Emergency Contact: ______________________________ Telephone #: ____________

Delhi Community Health Center

109 Elm Street, Delhi, Louisiana 71232 \ (318) 878-66 0

Pt ID #: ____________________

Patient Rights and Responsibilities

Delhi Community Health Center - Behavioral Health Services shall support and protect the fundamental human, civil, constitutional, and statutory rights of all its patients. The rights of each patient and how they are exercised are described below:

You have the right:

- To receive considerate and respectful care at Delhi Community Health Center.
- To receive an explanation of your diagnosis, treatment, and prognosis in terms you can understand.
- To receive the necessary information to participate in decisions about your care and to give your informed consent before any diagnostic or therapeutic procedure is performed.
- To expect that your personal privacy will be respected by all staff members at Delhi Community Health Center.
- To expect that your medical records will be kept confidential and will be released only with your written consent, in cases of medical emergencies, or in response to court orders. (Confidentiality can be breached if the individual poses a significant threat of harm to self or others).
- To know the names and positions of people involved in your care by official name tag or personal introduction.
- To ask and receive an explanation of any charges made by Delhi Community Health Center, even if they are covered by insurance.
- To obtain another medical opinion prior to any procedure.
- To review any medical records created and maintained by Delhi Community Health Center regarding your care and treatment.
- To effective pain management and to be informed by staff about available measures.
- To be made aware of advance directives, and to know how this organization will respond to such advance directives.
- To care which takes into consideration your psychosocial, spiritual, and cultural values.

You are responsible:

- For providing accurate information about your past health history.
- For asking questions if you do not understand the explanation of your diagnosis, treatment, prognosis, or any instructions.
- For providing the necessary information to complete your file.
- For any charges billed to you.
- For following the rules and regulations posted within Delhi Community Health Center.
- For providing your practitioner with at least a 24 hour notice when you or your family are in need of medications or a prescription.
- For arriving on time for appointments. If you are twenty-minutes or more late we cannot guarantee your appointment.
- For calling at least 24 hours in advance of your appointment to cancel and/or reschedule.

______________________________________   ____________________

Signature of Patient or Responsible Party   Date/Time

Delhi Community Health Center

109 Elm Street, Delhi, Louisiana 71232 \ (318) 878-66·0

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT
Delhi Community Health Center/BHI 2021

CONSENT FOR TREATMENT: I authorize Delhi Community Health Center and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, as they determine necessary for an annual year. I understand that my condition may call for a consultation with another Healthcare Provider. If this situation occurs, I authorize DCHC to release any medical information that may be needed to better provide for my medical treatment.

NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition related health care services.

Medicare: Please provide a copy of your Medicare card and any supplemental insurance card at each visit. If you have a share of the cost for your visit, you will be asked to pay that amount at the time of service**. By providing household income and family size, you may qualify for DCHC Sliding Fee Discount Program.**

Medicaid: Please provide a copy of your current Medicaid card at each visit. Medicaid covers all services provided at DCHC. You will have no cost sharing if you receive covered services under your Louisiana Medicaid or Medicaid Managed Care Plan. If you are covered under the "Take Charge" program, you only qualify for family planning services and defined conditions; you are responsible for payment of all other services.

Private Insurance: Please provide a copy of your current insurance card at each visit. Some insurance plans pay a percentage of charges. You are responsible for paying the remaining charges. Other insurance companies require a co-payment at each visit (stated on back of insurance card). You are responsible for pre-paying the co-pay amount prior to each visit.

Self-pay/no insurance: DCHC has programs that can help you pay for your healthcare. You may apply for insurance enrollment assistance through our Enrollment Assistance Program. You may also apply for DCHC Sliding Fee Discount Program which takes into consideration your annual household income and family size. You must apply for these programs and submit any required documents. Prescription Assistance is also available to patients who meet the income level and drug manufacturer requirements. (there is a nominal fee associated with administration of this program)

Types of Payments: DCHC accepts check payments. If a check payment is returned for insufficient funds, we will attempt a second time to obtain payment through your banking institution. Following a second attempt without payment, we will try to contact you by phone to resolve the matter. If an acceptable resolution cannot be reached following our discussion, or we are unable to contact you, we must turn the matter over to the authorities. After this point, check payments will not be accepted. We also accept credit card payments. We can discuss maintaining your credit card information on file at DCHC if you are interested in this option. When your payment is in cash, you will be provided with a receipt so that you will have a record of your payment. Please make us aware if you are not provided a receipt for a cash or credit card payment.

Delhi Community Health Center

109 Elm Street, Delhi, Louisiana 71232 \ (318) 878-66·0

Filing Insurance: DCHC will file your medical insurance as a courtesy to you. However, it is important to remember that your insurance is a contract between you and your insurer. You are responsible for payment of services regardless of the amount your insurance pays.

I realize that I am responsible for any and all differences in charges and payments. I understand that I may be eligible for the DCHC Sliding Fee Discount Program but unless I meet all requirements of this program, I am responsible for the entire bill. I understand that it is my responsibility to inform the staff of DCHC of any changes in my income, family status, or insurance status. I understand that it is my responsibility to update financial paper work on a yearly basis. I further understand that providing DCHC with false information will result in immediate recalculation of the sliding fee scale for those patient fees occurring during the fraudulent periods and all fees will be due and payable immediately.

By signing below you give your consent for treatment at DCHC, acknowledge receipt of our HIPAA privacy practices and agree to our financial policy.

X____________________	X____________________	X__________
Print Name of Patient	Signature of Patient or Responsible Party	Date

Thank you for choosing DCHC as your healthcare provider. Please let us know if you have questions or concerns.

You will receive a separate billing statement from Delhi Hospital or other source if additional tests were done outside DCHC. If you qualify for the Sliding Fee Discount Program at DCHC, the discounts will also apply at Delhi Hospital and Delhi Rural Health Clinic. You will be notified prior to any service if there are subsequent charges over and above the usual and customary fees associated with a typical visit. (i.e. supplies or equipment) Delhi Community Health Center locations and website have instructions on how to contact us after hours and what to do in case of emergencies.

For after-hours contact call 318.878.6650.
For after-hours emergencies dial 911 or go to the nearest emergency room.

DELHI COMMUNITY HEALTH CENTER **Pt ID #:** ______________

Telemedicine Patient Consent Form

I, (name of patient or parent/guardian) ____,
agree to participate in a telemedicine evaluation. I have been informed of the current public health order that directs healthcare providers to transition in-person healthcare services to telemedicine technology when medically appropriate. I understand that in the medical opinion of my healthcare provider the delivery of services via telemedicine will be consistent with the standard of care for an in-person visit. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person. My health care provider has explained to me how the video conferencing technology will be used and that there may be limitations and restrictions to the visit which include, for example: no physical examination being conducted and no instruments will be used such as stethoscopes, otoscopes.

I understand there are potential risks to this technology, such as interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
I am aware of how to contact my provider in the event technical difficulties do occur as well as for follow up, emergency care or to obtain copies of my medical records.

By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

Patient Consent to Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Signature of patient (or parent/guardian): ______________________________ **Date:** ____________

Please print the above name: ____

Signature of witness: ____ Date: ______________

( ) (CHECK AND SIGN BELOW FOR <u>WITHDRAWAL</u> ONLY). I have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian): ______________________________ Date: ______________

Signature of witness: ____

DELHI COMMUNITY HEALTH CENTER
BEHAVIORAL HEALTH SERVICES

Pt ID#: ____________

Consent to Obtain Information

I, ____, do give permission for the staff at Delhi Community Health Center, Behavioral Health Services, to talk to the following person(s) and exchange information regarding the care of myself/my minor child.

1. **Primary Care Provider (PCP):** ____

Phone: (Work) ______________________________ (Fax) ______________________________

2. **Specialist Provider:** ______________________________ Specialty: ____________________

Phone: (Work) ______________________________ (Fax) ______________________________

3. Name: ______________________________ Relationship: ____________________

Phone: (Cell) ____________________ (Home) ____________________ (Work) ____________________

4. Name: ______________________________ Relationship: ____________________

Phone: (Cell) ____________________ (Home) ____________________ (Work) ____________________

5. Name: ______________________________ Relationship: ____________________

Phone: (Cell) ____________________ (Home) ____________________ (Work) ____________________

______________________________ ____________________

Patient Signature Date/Time

______________________________ ____________________

Witness Signature Date/Time

Delhi, LA

Delhi Community Health Center

109 Elm Street, Delhi, La 71232 I Phone: (318) 878-8656

Pt ID #: ______________

Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser Unless:

(1) The patient consents in writing,

(2) The disclosure is allowed by a court order, or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.)

Patient Signature: ______________________________ Date/Time: ________________

Witness Signature: ______________________________ Date/Time: ________________