Bluestone Health Association, INC

Bluestone Health Center
Bluestone Medical Center
Bluestone Family Practice
Prudich Medical Center
Southtern Bluestone Health Center

Bluestone Health Association, Inc.

PATIENT INFORMATION:			
LAST NAME:	**FIRST NAME:**	**M.I.:**	**PREVIOUS NAME IF APPLICABLE:**
MAILING ADDRESS:			**APARTMENT NUMBER:**
CITY/STATE/ZIP		**EMPLOYER:**	
HOME PHONE:	**CELL PHONE:**		**WORK PHONE:**

PREFERRED METHOD OF CONTACT FOR REMINDER CALLS & OTHER ELECTRONICALLY MESSAGES: ○ VOICE ○ TEXT ○ MAIL	**IF VOICE, PLEASE SELECT PREFERRED NUMBER:** ○ HOME ○ CELL ○ WORK
EMAIL ADDRESS:	**CAN WE LEAVE A MESSAGE REGARDING YOUR MEDICAL CARE AND TEST RESULTS?** ○ YES ○ NO

MARITAL STATUS:	**DATE OF BIRTH:**	**SEX:** ○ MALE ○ FEMALE	**SOCIAL SECURTIY NUMBER:**

CITIZENSHIP/IMIGRATION STATUS: *(This information is requested to determine eligibility for federally funded services and is kept confidential in accordance with applicable laws and regulations.)*

- ○ **U.S. CITIZEN**
- ○ **LAWFUL PERMANENT RESIDENT (GREEN CARD HOLDER)**
- ○ **LAWFULLY PRESENT (e.g., Asylee, Refugee, Temporary Protected Status, Work Visa, Student Visa, etc.)**
- ○ **NOT LAWFULLY PRESENT (Undocumented or Other)**

RACE (PLEASE SELECT):	**ETHNICITY:**	**PREFERRED LANGUAGE:**
○ WHITE ○ HISPANIC ○ AMERICAN INDIAN OR ALASKA NATIVE ○ BLACK OR AFRICAN AMERICAN ○ ASIAN ○ NATIVE HAWIAIIAN OR PACIFIC ISLANDER ○ OTHER ○ DECLINE	○ HISPANIC OR LATINO ○ NOT HISPANIC OR LATINO ○ DECLINE	○ ENGLISH ○ SIGN LANGUAGE ○ BOSNIAN ○ SPANISH ○ INDIAN ○ RUSSIAN ○ OTHER

EMERGENCY CONTACT NAME AND TELEPHONE NUMBER:	**RELATIONSHIP TO PATIENT:**

DO YOU HAVE ANOTHER FAMILY PHYSICIAN OR PEDIATRICIAN OTHER THAN BLUESTONE? IF SO, WHO?

Bluestone Health Association, Inc.

PATIENT INFORMATION: ***(CONTINUED)***			
PREFERRED PHARMACY NAME AND LOCATION:			
PATIENT'S MOTHERS MAIDEN NAME:			
RESPONSIBLE PARTY: *IF THE PATIENT IS A MINOR (UNDER THE AGE OF 18), THE PARENT OR GUARDIAN BRINGING THE PATIENT WILL BE LISTED AS THE GUARANTOR*			
LAST NAME:	**FIRST NAME:**	**DATE OF BIRTH:**	**SOCIAL SECURITY NUMBER:**
ADDRESS OF RESPONSIBLE PARTY:			**CITY/STATE/ZIP**
TELEPHONE NUMBER OF RESPONSIBLE PARTY:			**RELATIONSHIP TO PATIENT:**
PRIMARY MEDICAL INSURANCE: **INSURANCE COMPANY NAME:** _____ **POLICY HOLDER NAME:** _____ **DATE OF BIRTH:** _____ **POLICY NUMBER:** _____ **PATIENT RELATIONSHIP TO POLICY HOLDER:** _____			**PLEASE PROVIDE UPDATED PRIMARY MEDICAL INSURANCE CARDS TO THE OFFICE STAFF**
SECONDARY MEDICAL INSURANCE: **INSURANCE COMPANY NAME:** _____ **POLICY HOLDER NAME:** _____ **DATE OF BIRTH:** _____ **POLICY NUMBER:** _____ **PATIENT RELATIONSHIP TO POLICY HOLDER:** _____			**PLEASE PROVIDE UPDATED SECONDARY MEDICAL INSURANCE CARDS TO THE OFFICE STAFF**

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize Bluestone Health Association or insurance company to release any information required to process my claims. I voluntarily consent to Medical Treatment by the clinical staff for myself or the above-mentioned minor. MEDICARE BENEFICARIES: I request that payment of authorized Medicare benefits be made to BHA. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ **DATE:** _____

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Bluestone Dental

Please Read Before Completing Initial Visit Packet

Policies are in place that may affect your initial visit experience at our clinic. If your main complaint is ***CHRONIC PAIN*** (pain lasting longer than 3 months), be aware that we follow policies (Senate Bill 237) enacted by our state government. You will be subjected to a drug screen, any illegal substances will be reported to WVDHHR, your medication history will be investigated via the Controlled Substance Monitoring Program which links prescription information to a central database for the purpose of limiting diversion (selling or giving away medication) and malingering (coming to the doctor just to gain pills.)

Prescribing practices are at the medical discretion of the provider. If this is your first visit and you do not provide adequate proof of severe injury or disability in the form of recent doctor records, MRI results, and/or X-ray studies, it is ***HIGHLY UNLIKELY*** that you will be treated with Opioid Pain Medication.

These include: **Oxycodone, Hydrocodone, Hydromorphone, Codeine, Morphine, Buprenorphine, Tramadol, or any of their trade name equivalents.**

This does not mean that we will not try our best to help you to discover the issues causing your pain or deny you any evidence-based therapy to better control your painful state.

If you are agreeable to these medications, please sign and date below.

X_____/_____/_____

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Bluestone Dental

PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____

ALLERGIES: _____

LIST ALL THE MEDICATIONS YOU TAKE, INLUDING OVER-THE-COUNTER (OTC) MEDICATIONS & VITAMINS. INCLUDE SPECIFIC DOSES & WHEN TAKEN. IF YOU DON'T KNOW, PLEASE CALL YOUR PHARMACIST TO CONFIRM.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (Irregular Heartbeat)
Arthritis
Asthma
Bipolar
Bladder Problems/Incontinence
Bleeding Problems
Cancer: _____
Headaches
Crohn's Disease
COPD/Emphysema
Dementia
Depression
Diabetes 1 or 2
Diverticulitis
DVT (Blood Clot)
Gerd (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease
High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Macular Degeneration
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular
Peptic Ulcer
Psoriasis
Pulmonary Embolism
Rheumatoid Arthritis
Seizure Disorder
Sleep Disorder
Stroke
Thyroid Disorder
Ulcerative Colitis

Last Menstrual Period		**Date:**	**Normal or Abnormal**
Colonoscopy	**Yes or No**	**Date:**	**Normal or Abnormal**
Mammogram	**Yes or No**	**Date:**	**Normal or Abnormal**
Dexa (Bone Desnity)	**Yes or No**	**Date:**	**Normal or Abnormal**
Pap Smear	**Yes or No**	**Date:**	**Normal or Abnormal**

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE:

_____

_____

_____

SRUGICAL HISTORY: (PLEASE LIST ALL PRIOR SURGERIES & APPROX. DATES

_____

_____

SOCIAL/CULTURAL HISTORY

Education Level: ○ Elementary ○ High School ○ Vocational ○ College ○ Grad/Professional
Are there any vision problems that affect your communication? ○ Yes ○ No
Are there any hearing problems that affect your communication? ○ Yes ○ No
Are there any limitations to understanding or following instructions? ○ Yes ○ No

Current Living Situation (CHECK ALL THAT APPLY):
○ Single Family Household ○ Multi-generational household ○ Homeless ○ Shelter
○ Skilled Nursing Facility ○ Other:_____

Smokin/Tobacco use: ○ Current ○ Past ○ Never ○ Type:_____ Amount/Day:_____ #/YRS_____

Alcohol: ○ Current ○ Past ○ Never Drinks/week: _____

Recreation Drug Use: ○ Current ○ Past ○ Never Type: _____

Are you sexually Active? ○ Yes ○ No

Are there any personal problems or concerns at home, work, or school that you would like to discuss?

○ Yes ○ No

Are there any cultural or religious concerns you have related to our delivery of care? ○ Yes ○ No

Are there any financial issues that impact your ability to manage your health? ○ Yes ○ No

How often do you get the social and emotional support you need?

○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

Comments (Please feel free to comment on any answers marked "yes" above)

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:_____	Diabetes 1 or 2	High Blood pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid
Arthritis	Dementia	Heart disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:_____	Diabetes 1 or 2	High Blood pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid
Arthritis	Dementia	Heart disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List any other medical providers you see on a regular basis (ie. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

PATIENT SIGNATURE: _____ DATE: _____

Clinic Privacy Notice

BLUESTONE HEALTH ASSOCIATION, INC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Bluestone Health Association, Inc. is committed to providing quality health care while protecting the privacy of your health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) and your rights to access and control your information. "Protected health information" is health information that identifies you, such as information concerning your past, present or future physical or mental conditions, care you have received or payments made for such care. We also are required to provide you with this notice of our legal duties, our privacy practices and your rights concerning your PHI. We are required to follow the terms of the notice of privacy practices we have in effect at the time. As noted above this notice is affective for health care services provided on and after April 14, 2003 until we revise or replace it.

We reserve the right to revise or amend our Notice of Privacy Practices at any time. Any revision or amendment to our Notice will be effective for all PHI that our organization has created or maintained in the past, and for any PHI that we may create or maintain in the future. Our organization will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER AT (304) 431-5499.

WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT. PAYMENT AND OUR OPERATIONS AND AS OTHERWISE PERMITTED IN THE FOLLOWING WAYS

Treatment: We may use PHI to treat you. For example, we may ask you to have laboratory tests and we may use the results to help us reach a diagnosis. Our medical staff may use or disclose PHI in order to treat you or to refer you to other health care providers to assist in your care.

Payment: We may use and disclose PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will pay for your treatment.

Healthcare Operations: We may use or disclose PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, we may use PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our organization.

Other Permitted Uses: We may use or disclose PHI to remind you of appointments or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. Unless your make an alternative request, we may send postcards to your home or le aye messages on your answering machine or with whomever answers your phone to remind you of appointments, to ask you to contact us concerning your care or to seek or coordinate your participation in programs we offer, such as disease management programs. We may also send you newsletters concerning treatment or care alternatives, benefits, services and containing general health care information. We may share your protected health information with third party "business associates" that perform various activities for us; however, we will require protection of PHI in our written agreements with our business associates. We may also use and disclose PHI for certain of our fund raising activities as permitted by applicable regulations. If you do not want to receive these materials, please contact our Privacy Officer and provide a written request to be removed from our distribution list for these materials.

We may also use or disclose PHI in accordance with federal and state law in the following situations that do not require your authorization for an opportunity for you to object:

Required By Law: We may use or disclose your PHI as required by law, such as when required by the Secretary of the Department of Health and Human Services to determine our compliance with privacy laws and regulation.

Public Health: We may disclose PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. We may also use or disclose PHI for the purpose of controlling disease, injury or disability or to prevent the spread of communicable diseases. West Virginia law requires reporting of: child or vulnerable adult abuse; weapon or burn-related injuries; communicable diseases; cancer; lead poisoning; and duty to warn of imminent harm. Our disclosure of PHI will be limited to the relevant requirements of the law.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Such oversight agencies include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of suspected abuse, neglect or domestic violence consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose PHI as required by the Food and Drug Administration to report adverse events, product defects or problems.

Legal Proceedings: If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We may also disclose PHI in response to a subpoena, discovery request, or other lawful process, but only if the party making the request has made efforts to notify you about the request or to obtain a protective order.

Law Enforcement: We may also disclose PHI for certain law enforcement purposes. These include (1) to respond to a court order or as otherwise required by law; (2) limited information requests for identification and location purposes; (3) pertaining to suspects, fugitives, material

witnesses, crime victims, or missing persons; (4) suspicion that death has occurred as a result of criminal conduct, (5) concerning a crime on our premises; and (6) to report a crime in emergency circumstances.

Coroners, Funeral Directors: and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes for determining cause of death or for other duties authorized by law. We may also disclose PHI to funeral directors to carry out their duties. PHI may be used and disclosed for organ, eye or tissue donation purposes.

Research: We may disclose PHI to researchers when their research has been approved by an institutional Review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information. We may disclose PH) to prevent or lessen a serious and imminent threat to the health or safety of the public or another person.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

Workers' Compensation: We may disclose PHI to comply with West Virginia Workers' Compensation laws.

Inmates: We may use or disclose PHI concerning inmates of a correctional facility that we created or received in the course of providing care to such inmates.;

USES AND DISCLOSURES OF PHI THAT MAY BE MADE UNLESS YOU OBJECT

We may use and disclose your PHI in the following instances unless you object. If you are not present or able to agree or object to the use or disclosure of the PHI, then we may, using our professional judgement, determine whether the disclosure is in your best interest, in this case, only PHI that is relevant to your health care' will be disclosed. Unless you object, we may disclose PHI: .- to a member of your family, a relative, a close friend or any other person that you involve in your health care, but only to the extent that the PHI directly relates to that person's involvement in your health care; - to notify a family member or other person responsible for your care of your location, general condition or death; or .- to entities (such as the American Red Cross) to assist in disaster relief efforts.

USES AND DISCLOSURES OF PHI BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke such authorization at any time, in writing, except to the extent that our organization has taken any action in reliance on the use or disclosure indicated in the authorization.

MORE STRINGENT REQUIREMENTS UNDER WEST VIRGINIA LAW

You should note that the foregoing summary of permitted uses and disclosures of PHI is based upon federal requirements are to be followed unless West Virginia law offers PHI greater protection. In certain situations, West Virginia has adopted stronger protections for PHI than the federal provisions. Since we are providing your health care in West Virginia, these laws will apply, even though you may be a citizen of another state. In West Virginia, mental health information obtained in the course of our care for is considered to be confidential and may not be disclosed without patient authorization, by qualified court order or where necessary to protect someone from clear and substantial danger of imminent harm, For this purpose, mental health information includes the (fact someone is our patient or has received treatment; Information related to diagnosis or treatment and PHI concerning physical, mental or emotional condition and advice, instructions or prescriptions related to such care, treatment or diagnosis. Also under West Virginia law, we may not release or disclose PHI of a minor receiving treatment or services for birth control, prenatal pare, drug rehabilitation or venereal disease without the minor's Prior written consent (even to parents or guardians). Under West Virginia law, the identity of a person who has received an HIV-related test and the results of such test may not be disclosed Without the person's consent. However, disclosure is permitted to certain parties, such as to the victim of a sexual assault or to health care workers involved in the treatment of the person. Recipients of such information under on of these exceptions are prohibited from re-disclosing the PHI. We also cannot disclose to third parties PHI concerning substance abuse treatment without patient authorization.

THE FOLLOWING IS A STATEMENT OF YOUR RIGHTS REGARDING YOUR PHI AND HOW YOU MAY EXERCISE THESE RIGHTS:

You have the right to Inspect and copy your protected health Information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records that we use for making health care or business operation decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to such information or was obtained from someone other than a health care provider upon a condition of confidentially. You may request an appointment to inspect and copy your PHI by completing an Access Request form and submitting it to our Privacy Officer. If your request is granted, we will schedule a mutually convenient time for such action. We are required to respond to your request to inspect and copy your records within 30 days of receipt of your request if the requested information is maintained on-site (60 days if off-site), unless we extend this response time by up to an additional 30 days, with written notice to you of the reasons for the delay and the date by which we will complete our action on your request. We may deny your request to inspect and copy your records in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. One of our medical staff will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Please note that all original health records created by us in the course of your care remain our property. We are required to take reasonable measures to safeguard these records and to prevent unauthorized additions, deletions, or changes in these documents. Accordingly, while you have a general right to inspect and copy your medical records under federal and state law, we must control the conditions and circumstances under which any inspection and

copying occurs. No patient or authorized representative will be permitted unsupervised access to any medical record and no medical records may leave our control for inspection and copying purposes. We may charge you a fee for the cost of copying, mailing or searching these records in accordance with applicable laws, except where prohibited by such governing laws and regulations. If you request, we may prepare a summary of your PHI (a fee will be charged). You may request information concerning our fees from our Privacy Officer.

You have the right to request a restriction of your protected health Information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations or to family members or friends who may be involved in your care. Your request must state the specific restriction requested. We are not required to agree to a restriction that you may request. If our health care providers believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If our health care providers do agree to the requested restrictions, we may not use or disclose your PHI as restricted unless it is needed to provide emergency treatment or in the event the restriction is terminated. You may request a restriction by completing a Request for Restriction of PHI form and submitting it to our Privacy Officer. Copies of these forms may be obtained from our Privacy Officer.

You may request to receive communications from us by alternative means: For example, you may ask that we only contact you at home, not at work. We will accommodate requests. We may condition this accommodation by asking you for information as to how payment will be handled. We will not request a reason for your request. Please make this request to our Privacy Officer by completing an Alternative Contact Request Form that is available from our Privacy Officer.

You have the right to request amendment of your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. To request an amendment, your request must be on forms available from our Privacy Officer (Request for Amendment/Correction of PHI). You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support your request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendments;

- Is not part of the designated record set kept by us;

-Is not part of the information which you would be permitted to inspect and copy; or

-Is accurate and complete

If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. We will provide you with a copy of any such rebuttal. Your statement of disagreement may not exceed 250 words. If you submit a statement of disagreement or clearly indicate in writing that you want your request for amendment to be made part of your medical record, we will attach it to your records and include in whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

You have the right to receive an accounting of certain disclosures of your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations or as otherwise permitted by law. It also excludes disclosures we may have made to you or to others pursuant to your authorization or to family members or friends involved in your care. You may request an accounting of these disclosures for up to six years prior to the data on which your accounting is requested or a shorter time frame; however, we are not required to include any disclosures prior to April 14, 2003. The right to receive this information is subject to certain other exceptions, restriction and limitations. The first accounting of disclosures you request within a 12-month period is free of charge, but our organization may charge you for additional requests, and you may withdraw your request before you incur any costs.

You have the right to obtain a paper copy of the notice from us. Upon request, even if you have agreed to accept this notice electronically. You may contact our Privacy Officer for a paper copy.

Complaints: You may complain to us or to the Secretary or Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer at (304) 431-5499 for further information about the complaint process.

Bluestone Health Association has Mal-Practice coverage under Federal Tort Claim Act (FTCA) through Federal Government.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, HAVE RECEIVED A COPY OF BLUESTONE HEALTH ASSOCIATION, INC.'S NOTICE OF PRIVACY PRACTICE.

_____ _____
Signature of Patient Date

Permission to Discuss Medical Information

Date:_____

I, _____, give permissions for providers at Bluestone Health Association, Inc. to discuss my medical care with:

Name: _____D.O.B_____
Relationship: _____Contact Number: _____

Name: _____D.O.B_____
Relationship: _____Contact Number: _____

Name: _____D.O.B_____
Relationship: _____Contact Number: _____

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MEDICAL CONSENT TO TREAT A MINOR

I, _____, the parent/legal guardian of _____, born on the _____ day of _____, 20_____ do herby consent and allow the following to handle any type of medical care for my child.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

This authorization is effective from this _____ day of _____, 20_____ and expires on the _____ day of _____, 20_____.

Any minor receiving ANY vaccine must be accompanied by the parent/legal guardian. If the clinic does not have the vaccine the day of the appointment, by signing this consent, this allows the minor to return to the clinic without adult supervision to receive the vaccine when available.

(This applies to children ages 16-18 to return without a parent to get a vaccine.)

Father's Phone #: _____ Mother's Phone # : _____

_____	_____	_____
Signature of Parent/Guardian	**Date**	**Printed Name**
_____	_____	_____
Signature of Witness	**Date**	**Printed Name**

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Consent to Receive Lab Results via Mail or Voicemail

I hereby give permission to Bluestone Health Association, Inc. to mail my lab results to me at the following address:

_____.

Mailing Address

I also give permission for Bluestone Health Association, Inc. to leave any confidential lab results on my voicemail (____) _____-_____.

I understand that it is my responsibility to update my address and telephone number with the office annually or whenever a change of address or telephone number occurs.

_____ _____

Patient Signature **Date**

(VALID FROM YEAR FROM DATE COMPLETED)

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Bluestone Health Clinic	

Greetings! We are giving you this letter today to inform you of our Sliding Fee Scale Program to bring into your first appointment!

HOW THE SLIDE WORKS:

You can be eligible for the slide whether you have ***insurance or not.*** The slide is based on poverty guidelines as outlined by the Department of Health and Human Services annually.

We are enclosing a slide application for your convenience today, please complete and return it to us by your next appointment date ***along with proof of income and number of people in your household.*** Proof of income accepted: W-2 forms, check stubs for the past 3 months from employer, award letter from Social Security, Veterans benefits, or a letter from the Department of Human Services, a friend or family member stating you have no income, with their name and phone number so that we can call to verify. Please advise us of spouse so his/her information may be updated at the same time with this application.

If you have received this and **do not wish to participate** in our slide program, **simply leave the slide application blank and sign the refusal letter enclosed and bring it back on your next appointment day.** We do, however, offer this to all patients and know that for many it is important to receive this discounted service for their healthcare.

We appreciate your continued faith and support in our facilities and strive to do our very best to help you maintain a healthy and prosperous life.

You may email or fax your proof of income to us in advance
to save some time when you come in!

Email:

Email:

OR

Fax:

Best Regards,

Bluestone Health Association, Inc.

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SLIDING FEE SCALE: FORM SITE: _____

First Name:	Middle Name:	Last Name:	Other names:
Home Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone Number:	Date of Birth:	Social Security Number:	Do you have Insurance? Yes No
Marital Status: Single	In a relationship	Married	Divorced Separated Widowed

HOUSEHOLD SIZE

NAME:	DATE OF BIRTH	SOCIAL SECURITY NUMBER

HOUSEHOLD INCOME

Name	Amount	Frequency Circle One	Employer
You		Weekly Monthly Yearly	
Spouse		Weekly Monthly Yearly	
Children		Weekly Monthly Yearly	
Other		Weekly Monthly Yearly	
		Weekly Monthly Yearly	
Total		Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Your yearly income tax return, a copy of your W•2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Sliding Fee Scale:

A - $10.00
B - $15.00
C - $25.00
D- $35.00
E - $45.00

I do hereby swear or affirm that the information provided is true and correct to the best of my knowledge and belief. I agree that any misleading and falsified information, and/or admissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Bluestone Health Association, Inc. if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Bluestone Health Association, Inc. I hereby acknowledge that I read the foregoing disclosure and understand it.

Patient Name: _____ Signature: _____ Date: _____

Bluestone Health Association, Inc.

Bluestone Health Center
Prudich Medical Center
Bluestone Primary Care
Bluestone Health Clinic
Bluestone Family Practice
Bluestone Medical Center
Bluestone Dental

GENDER QUESTIONNAIRE

Do you think of yourself as:

- Lesbian, Gay, or Homosexual
- Straight or Heterosexual
- Bisexual
- Something else, please describe _____
- Don't know

What is your current gender identity?

Check ALL that apply

- Male
- Female
- Female-to-Male (FTM)/Transgender Male/Tran Man
- Male-to-Female (MTF)/Tansgender Female/Tans Woman
- Genderqueer, neither exclusively male nor female
- Additional Gender Cataegory/ (or Other), please specify _____
- Decline to answer, please explain why_____

What sex were you assigned at birth on your original birth certificate?

(Check one)

- Male
- Female
- Decline to Answer, please explain why _____

NAME:_____ **DATE:**_____

1. How often do you have a drink containing alcohol? (0) Never (Skip to Questions 9-10) (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost Daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7,8, or 9 (4) 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily Skip to Questions 9-10 if Total Score for questions 2-3=0.	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of drinking? (0) N0 (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking. (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative, friend, doctor, or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year

RECORD TOTAL HERE:

NAME:_____ **DATE:**_____

RECORD TOTAL HERE: