LEGACY COMMUNITY HEALTH

# ADULT CLIENT INTAKE

| OFFICE USE ONLY PATIENT ID NUMBER |
|---|
| |

All information is strictly confidential to the full extent permitted by law unless we are legally required to disclose information. 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 that you complete this document in its entirety.

| PATIENT NAME | PREFERRED NAME (IF APPLICABLE) | MOTHER'S MAIDEN NAME |
|---|---|---|
| | | |

| TODAY'S DATE | DATE OF BIRTH | DRIVERS LICENSE NUMBER |
|---|---|---|
| | | |

| ADDRESS | CITY/STATE | ZIP |
|---|---|---|
| | | |

| COUNTY | BIRTH STATE/COUNTRY | SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |

| MAIN PHONE NUMBER | OTHER PHONE NUMBER | EMAIL ADDRESS |
|---|---|---|
| | | |

**PREFERRED METHOD OF CONTACT**

☐ Home Phone ☐ Fax ☐ Patient Portal ☐ Work Phone
☐ Email ☐ Letter ☐ Cell Phone

Okay by telephone? ☐ Yes ☐ No Okay to leave message? ☐ Yes ☐ No Okay to Send Mail? ☐ Yes ☐ No

**MARITAL STATUS**

☐ Single ☐ Married ☐ Living with Domestic Partner ☐ Divorced ☐ Other:

**GENDER**

What sex were you assigned at birth? (on your original birth certificate) ☐ Male ☐ Female

What is your current gender identity?

☐ Male ☐ Transgender Male / Female to Male ☐ Non-Binary ☐ Choose not to disclose
☐ Female ☐ Transgender Female / Male to Female ☐ Other

**SEXUAL ORIENTATION**

☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Other
☐ Don't Know ☐ Choose not to disclose

**PREFERRED LANGUAGE**

☐ English ☐ Spanish ☐ Other:


Orig. 12/2013; Rev. 11/2015, 3/2016, 4/2016, Exp. 4/2017

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**NAME:** _____

**RACE (if multi-racial, choose all the apply)**

☐ Asian ☐ Black/African American ☐ Choose not to disclose
☐ Native Hawaiian ☐ American Indian/Alaska Native
☐ Other Pacific Islander ☐ White

**ETHNICITY**

☐ Hispanic ☐ Non-Hispanic ☐ Declined to State

| OCCUPATION | HOMELESS | U.S. MILITARY VETERAN |
|---|---|---|
| | ☐ Yes ☐ No | ☐ Yes ☐ No |

**AGRICULTURAL WORKER**

☐ Yes ☐ No If yes: ☐ Seasonal ☐ Employed Year-Round ☐ Retired Farmworker

| FAMILY SIZE ( # of persons living in your home) | TOTAL FAMILY HOUSEHOLD INCOME |
|---|---|
| | ☐ Yearly ☐ Monthly |

PLEASE PROVIDE YOUR **EMERGENCY CONTACT** INFORMATION BELOW

| NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER |
|---|---|---|
| | | |

| ADDRESS | CITY/STATE | ZIP | COUNTY |
|---|---|---|---|
| | | | |

PLEASE PROVIDE **PRIMARY CAREGIVER** BELOW (Person responsible for providing day-to-day care for the patient. Appropriate documentation must be provided).

| NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER |
|---|---|---|
| | | |

☐ **N/A, I do not have a primary caregiver.** ☐ **Same as emergency contact**

PLEASE PROVIDE **PRIMARY LEGAL GUARDIAN** BELOW (Court appointed person to make healthcare decisions in place of patient. Appropriate documentation must be provided).

| NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER |
|---|---|---|
| | | |

☐ **N/A, I do not have a legal guardian.** ☐ **Same as emergency contact**

PLEASE PROVIDE PERSON WHO IS YOUR CHOICE FOR MEDICAL POWER OF ATTORNEY (HEALTHCARE PROXY) BELOW (Patient appointed person to make healthcare decisions in place of patient. Appropriate documentation must be provided).

| NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER |
|---|---|---|
| | | |

☐ **N/A, I do not have a healthcare proxy.** ☐ **Same as emergency contact**

| OFFICE USE ONLY PATIENT ID NUMBER |
|---|
| |

**NAME:** _____

**OTHER HEALTHCARE PROVIDERS**

| PROVIDER NAME | | | PHONE NUMBER |
|---|---|---|---|
| | | | |
| **ADDRESS** | **CITY/STATE** | **ZIP** | **COUNTY** |
| | | | |
| **PROVIDER NAME** | | | **PHONE NUMBER** |
| | | | |
| **ADDRESS** | **CITY/STATE** | **ZIP** | **COUNTY** |
| | | | |

**PHARMACY INFORMATION**

| PREFERRED PHARMACY | | | PHONE NUMBER |
|---|---|---|---|
| | | | |
| **ADDRESS** | **CITY/STATE** | **ZIP** | **COUNTY** |
| | | | |

**DO YOU HAVE ANY HEALTHCARE DIRECTIVES?**

☐ Yes ☐ No ☐ Medical Power of Attorney ☐ Directives to Physician and Family(Living Will)

**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? _____ Have you applied in the last 30 days? ☐ Yes ☐ No

**WHAT TYPE OF INSURANCE DO YOU HAVE?**

☐ None / Self Pay ☐ Other ☐ Medicare Plan ☐ Medicaid Plan ☐ Private Insurance

Insured ID: _____ Group Number: _____

Private Insurance: _____

PCP Provider if HMO Policy: _____

**INSURED/POLICY HOLDER INFORMATION**

| NAME | | SOCIAL SECURITY NUMBER | PHONE NUMBER |
|---|---|---|---|
| | | | |
| **ADDRESS** | **CITY/STATE** | **ZIP** | **COUNTY** |
| | | | |
| **DATE OF BIRTH** | **PATIENT'S RELATIONSHIP TO INSURED/POLICY HOLDER** | | |
| | ☐ Self ☐ Spouse ☐ Child ☐ Other: | | |

| OFFICE USE ONLY PATIENT ID NUMBER |
|---|
| |

**NAME:** _____

**INSURED'S EMPLOYER INFORMATION**

| COMPANY NAME | | | PHONE NUMBER |
|---|---|---|---|
| | | | |
| **ADDRESS** | **CITY/STATE** | **ZIP** | **COUNTY** |
| | | | |

**MARKETING**

| HOW DID YOU LEARN ABOUT OUR SERVICES? |
|---|
| ☐ Friend/Relative ☐ Print ☐ Radio/TV ☐ Internet ☐ Referral ☐ Community Event |
| Name of referral source: |

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. I will let the eligibility staff know should my income or number of people in my family change.

_____ _____

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

_____ _____

Signature of Person Who Helped Complete this Form | Date

| OFFICE USE ONLY | | | |
|---|---|---|---|
| Reviewed by: | | Date: | |

LEGACY COMMUNITY HEALTH

# ADULT CONSENT & ACKNOWLEDGMENT FOR SERVICES

| OFFICE USE ONLY PATIENT ID NUMBER |
| --- |
| |

**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)

LEGACY COMMUNITY HEALTH

# CONSENT FOR COMMUNICATION WITH DELEGATED INDIVIDUAL

| OFFICE USE ONLY PATIENT ID NUMBER |
| --- |
| |

**NAME:** _____

## NAME OF 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 |



Orig. 12/2013; Rev. 11/2015, 3/2016, 4/2016, Exp. 4/2017

LEGACY COMMUNITY HEALTH

# CONSENT AND ACKNOWLEDGEMENT FOR OBTAINING E-PRESCRIBING HISTORY

| OFFICE USE ONLY PATIENT ID NUMBER |
| --- |
| |

**NAME:** _____

## 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

| OFFICE USE ONLY PATIENT ID NUMBER |
| --- |
| |

**NAME:** _____

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



Orig. 12/2013; Rev. 11/2015, 3/2016, 4/2016, Exp. 4/2017

LEGACY COMMUNITY HEALTH

**RELEASE OF INFORMATION & ENROLLMENT CONSENT**
**GREATER HOUSTON HEALTH CONNECT**

| OFFICE USE ONLY PATIENT ID NUMBER |
| --- |
| |

**NAME:** _____

I, _____, have been informed about the Greater Houston Healthconnect.

By signing I understand that (i) Legacy Community Health Services is a member of Greater Houston Healthconnect (GHH); (ii) GHH is a non-profit company coordinating my enrollment in a health network at no cost to me; (iii) GHH may not be able to obtain health care providers that are available to care for my condition at no cost to me; (iv) the healthcare providers who will be providing my treatment are independent and not employees of GHH; and (v) GHH does not provide, and is not responsible for any treatment or outcomes of treatment in connection with my membership

By signing, I agree to participate in the Greater Houston Healthconnect, and I understand that my protected health information and personal information will only be released for the purposes of my medical treatment, healthcare operations, payment, or pursuant to my authorization. I agree to notify my future health care providers of my enrollment in the GHH network to help facilitate the transfer of my medical records. I understand and consent to GHH maintaining records for me containing sensitive health information (examples: HIV status and/or information about mental health issues) if my health care provider believes this information is needed for my treatment. I authorize GHH and future health care providers to have access to those medical records that my health care providers feel are necessary for my medical treatment and/or continued screening.

By signing this consent form, I understand it will remain in effect until I submit a written request to leave the GHH network or sign a Request of Revocation to terminate my participation with the GHH. I understand that I may request a copy of my records by contacting my providers directly.

| PRINT PARTICIPANT FIRST NAME | PRINT PARTICIPANT LAST NAME | DATE OF BIRTH |
| --- | --- | --- |

| SIGNATURE OF PARTICIPANT (or Legally Authorized Representative) | DATE |
| --- | --- |

More information may be obtained by logging on to www.ghhconnect.org. Members of GHH will adhere to federal confidentiality, privacy and security procedures.