LEGACY COMMUNITY HEALTH

CLIENT INTAKE

Legacy Community Health No Show Policy
Effective 11/1/2018

Any patient who misses an appointment three times without calling in advance to reschedule or cancel, will no longer be able to schedule appointments by phone. Patients will only be able to schedule appointments, in person, at the front desk of one of our locations.

PATIENT FIRST NAME	PATIENT MIDDLE NAME	PATIENT LAST NAME	
PREFERRED NAME (IF APPLICABLE)	**MOTHER'S MAIDEN NAME**	**DATE OF BIRTH**	**AGE**

TODAY'S DATE	PARENT/LEGAL GUARDIAN NAME (IF PATIENT UNDER 18)	DRIVERS LICENSE OR OTHER ID

ADDRESS	CITY/STATE	ZIP

COUNTY	BIRTH STATE/COUNTRY	SOCIAL SECURITY NUMBER

MAIN PHONE NUMBER	OTHER PHONE NUMBER	HOMELESS?
☐ Home Phone ☐ Mobile Phone	☐ Home Phone ☐ Mobile Phone	☐ Yes ☐ No

EMAIL ADDRESS

MARITAL STATUS

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

GENDER (AT BIRTH)

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

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

PREFERRED METHOD OF CONTACT (Legacy may use any method listed below when necessary to contact you)

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

AGRICULTURAL WORKER

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

ETHNICITY

☐ Hispanic ☐ Non-Hispanic ☐ Declined to State

RACE (if multi-racial, choose all that apply)

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

PREFERRED LANGUAGE	U.S. MILITARY VETERAN
☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No

HOW DID YOU LEARN ABOUT OUR SERVICES?

☐ Friend/Relative ☐ Print ☐ Radio/TV ☐ Internet ☐ Referral ☐ Community Event

Name of referral source:

OFFICE USE ONLY PATIENT ID NUMBER	

Patients 18 years old and up, please answer the following questions:
1: **Sexual orientation** is the term used to describe what gender(s) someone is sexually and/or romantically attracted to.
2: **Gender Identity** is how we feel about and express our gender and gender roles — clothing, behavior, and personal appearance. It can be a feeling that we have as early as age two or three.

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

CURRENT GENDER IDENTITY			
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	

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

ADDRESS	CITY/STATE	ZIP	COUNTY

Does this person know that you are a patient of Legacy Community Health? ☐ Yes ☐ No

OTHER CONTACTS*	CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER	SAME AS EMERGENCY CONTACT	N/A
Primary Legal Guardian				☐	☐
Primary Caregiver				☐	☐
Power of Attorney				☐	☐
Delegated Individual				☐	☐
Other Healthcare Provider					☐

* Primary Legal Guardian is the court-appointed person to make healthcare decisions in place of the patient. Primary Caregiver is the person responsible for providing day-to-day care for the patient. Medical Power of Attorney (Healthcare Proxy) is the patient-appointed person to make healthcare decisions in place of the patient. The Delegated Individual is the patient-appointed person to communicate with about my healthcare, which may include information about my medical diagnosis, eligibility status and appointments. Appropriate documentation must be provided.

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)

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

Member Insured ID number: _____ Group Number: _____

Private Insurance Plan Name: _____ PCP Provider if HMO Policy: _____

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:		

INSURED'S EMPLOYER INFORMATION

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

I hereby grant Legacy Community Health (Legacy) permission to obtain this medication history electronically from other healthcare organizations, including but not limited to pharmacies. ☐ Yes ☐ No

Patient Information Documents

My signature below acknowledges I have been provided with a Patient Information Package, which includes a:

- Notice of Privacy Practices, explaining how my health information will be handled in various situations;
- Statement of Client Rights and Responsibilities, which I agree to abide by;
- Feedback/Concern/Complaint/Grievance Policy for filing complaints;
- E-Prescribing Information Sheet; and
- Legacy Patient Agreement.

Consent to Treatment, Testing, and Procedures

I consent to all tests, treatments and procedures ordered by Legacy providers including, without limitation, testing for communicable or blood-borne diseases such as sexually transmitted diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis. As part of my testing and treatment, I may receive disease-specific prevention, education, and risk-reduction services. I understand that Legacy is required by state law to report information to the City of Houston Department of Health & Human Services for persons who test positive for certain diseases (known as "reportable diseases") including, but not limited to, tuberculosis, HIV/AIDS, and syphilis. If I test positive for a reportable disease, I understand that I will be contacted by a state-authorized Disease Intervention Specialist to promote successful treatment and notification of any sex partners, if applicable, who may be at risk for the disease. I also understand that if a Legacy health care worker is accidentally exposed to my blood or body fluids, (for example by a needlestick), Legacy can draw and/or use blood drawn from me for testing purposes.

Financial Responsibility

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. As payers of last resort, grant-funded programs may not continue my eligibility if I currently or in the future have Medicare, Medicaid and/or third party insurance coverage. Therefore, I agree to immediately report any changes in my financial status and/or insurance coverage to the Eligibility Specialist. If I fail to appropriately report changes in my financial status and/or insurance coverage, and if those changes result in my ineligibility for services under a grant funded program, I understand that I am fully responsible for the cost of services delivered by Legacy.

Insurance Assignment

By signing below, if I am eligible for Medicaid, Medicare and/or third party insurance coverage while a client of Legacy, I authorize Legacy to furnish to Medicaid, Medicare and/or third party insurance coverage all of the necessary medical information, including my HIV status, to process my claim. I also hereby assign to Legacy all payments received from Medicaid, Medicare and/or a third party insurer for services and treatments provided to me by Legacy. I understand that I may be responsible for paying any required co-payments prior to being seen by a health care practitioner. I also understand that I am responsible for the cost of services and treatments delivered to me that are not covered by my insurance.

Research Participation

Legacy participates in research studies, which can involve proven or experimental treatments. By signing below, I authorize Legacy staff to review my information to determine if I qualify to participate in current or future studies. If I qualify, I will be notified and provided with the opportunity to accept or decline research participation. My signature below does not mean I agree to be in a research study.

E-Prescribing

E-Prescriptions, E-Rx or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. Legacy participates in E-prescribing because we care about your health and well-being and E-prescribing has multiple benefits. By consenting, Legacy can also access a history of my current and past prescriptions. This critical information assists Legacy in confirming the safety of my prescriptions and minimizing dangerous interactions with my other medications.

Greater Houston Healthconnect

Legacy participates in Healthconnect, a non-profit organization that provides a secure electronic network for Healthconnect participants. A list of current Healthconnect participants is available at www.ghhconnect.org. Legacy's participation with others in Healthconnect, such as labs, pharmacies, radiology centers, doctors' offices, hospitals, and health insurers, permits Legacy to access, and utilize in providing care to you, any available electronic health information related to you. All Healthconnect participants must protect your privacy in accordance with state and federal laws. Your treatment and eligibility for benefits will not be affected. By my signature below, I agree that Healthconnect and its current and future participants, including Legacy, may use and disclose my protected health information electronically for the limited purposes of treatment, payment and health care operations. I understand that Healthconnect may connect to other health information exchanges in Texas and across the country that also must protect my protected health information in accordance with state and federal laws, and I authorize Healthconnect to share my information with those exchanges for the same limited purposes of treatment, payment and health care operations. This authorization remains in effect unless and until I revoke it. I understand that I can revoke this authorization at any time by giving written notice to any healthcare provider who participates in Healthconnect and my revocation will be effective within three (3) days. I also understand that revoking this authorization does not affect information previously shared when my authorization was in effect.

Terms of Consent

I understand my consent is necessary for Legacy to offer services to me and that some items may not apply to my current situation. I also understand that, in order to provide comprehensive care during this and future visits, and to evaluate my eligibility for programs, my signature below indicating my agreement to this document in its entirety, is required. By signing this form, I acknowledge and agree to the terms, information and obligations contained in this document. I am giving this consent of my own free will. I have had the opportunity to read and ask any questions about the information in this packet, specifically including, but not limited to, the financial obligations provisions and assignment of benefit provisions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction in a language I understand. I sign this document freely and agree to abide by its terms. I understand that this document remains in effect until I revoke my consent, at any time, in writing. I also understand that revoking this authorization does not affect any actions previously taken based on this consent

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 Legacy eligibility staff any information necessary to confirm statements about my eligibility. I understand that giving false information could result in eligibility disqualification and a possible repayment obligation. I also agree to inform the eligibility staff 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
Signature of Witness	Date

OFFICE USE ONLY	
Reviewed by:	Date: