coös county Family Health

PATIENT INTAKE FORM

PATIENT DATA

PATIENT FIRST: _____**M**: _____**LAST**: _____

Mailing Address: _____**City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____**Work Phone:** _____ext: _____ **Other/Cell Phone**: _____

Date of Birth: _____ **Social Security #**: _____ **Sex:** □ **Female** □ **Male**

Email: _____ **Marital Status**: □ **Single** □ **Married** □ **Divorced** □ **Widowed**

IF PATIENT IS UNDER 18 YEARS OLD:

Father: _____ **Date of Birth:**_____

Address:_____ **Phone #:** _____

Mother: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

Legal Guardian (if other than parents):_____ **Address:** _____ **Phone #:** _____

EMERGENCY

EMERGENCY CONTACT: **Name:** _____ **Relationship:** _____

Address: _____ **City:** _____

State/Zip Code: _____ **Phone:** _____

****If patient is under 18 years old, proceed to Insurance Section. ****

EMPLOYMENT/RACE

NOTE: Coos County Family Health Services, as a Federally Qualified Health Center, we are required by Federal Law to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is NOT reported or disclosed. The collection of this information also assists CCFHS in applying for additional grant funds to support and expand its services. Thank you for your cooperation.

ARE YOU A VETERAN? □ **Yes** □ **No**

HAVE YOU OR A FAMILY MEMBER EVER SERVED IN THE MILITARY? □ **Yes** □ **No**

ETHNICITY: □ **Hispanic** □ **Non-Hispanic** □ **Decline to provide**

RACE: □ **White** □ **Black/African American** □ **Asian** □ **Native Hawaiian/Other Pacific Islander** □ **Native American/Native Alaskan**

SEXUAL ORIENTATION: □**Lesbian or gay** □**Straight** □**Bisexual** □**Something else** □**Don't know** □**Choose not to disclose**

GENDER IDENTITY: □**Male** □**Female** □**Transgender Male/Female-to-Male** □**Transgender Female/Male-to-Female** □**Other**□ **Choose not to disclose**

EMPLOYMENT STATUS: □ **Full-Time** □ **Part-Time** □ **Disabled** □ **Retired** □ **Unemployed**

Employer Name: _____ **Employer Phone Number:** _____

Number of household members: _____

Estimate of total household income (yearly):

□ **$ 0.00 - $15,000** □ **$15,001 - $30,000** □ **$30,001 - $45,000** □ **$45,001 - $60,000** □ **$60,001 - $75,000** □ **$75,001 - over**

→

☐ PRIMARY INSURANCE COMPANY NAME: _____

Policy Holder Name: _____ Policy ID#: _____

☐ SECONDARY INSURANCE COMPANY NAME: _____

Policy Holder Name: _____ Policy ID#: _____

☐ I HAVE NO INSURANCE *Coos County Family Health Services offers a Discount Program to our patients to ensure that income or lack of insurance is not a barrier to care. Patients who are not covered by public or private insurance or have limited means to cover their co-insurance may apply for our sliding fee scale. Please inquire with Front Office Staff or the Billing Department.*

Coos County Family Health Services Sliding Fee Schedule as of March 1, 2016

Family Size		A - $10 Fee 0-100%	B-80% Discount/$10 Min 101-133%	C-60% Discount 134-168%	D-40% Discount 169-200%	E-20% Discount * 201-250%
1	Yearly	0 11,880	11,881 15,800	15,801 19,958	19,959 23,760	23,761 +
	Monthly	0 990	991 1,317	1,318 1,663	1,664 1,980	1,981 +
	Weekly	0 228	229 304	305 384	385 457	458 +
2	Yearly	0 16,020	16,021 21,307	21,308 26,914	26,915 32,040	32,041 +
	Monthly	0 1,335	1,336 1,776	1,777 2,243	2,244 2,670	2,671 +
	Weekly	0 308	309 410	411 518	519 616	617 +
3	Yearly	0 20,160	20,161 26,813	26,814 33,869	33,870 40,320	40,321 +
	Monthly	0 1,680	1,681 2,234	2,235 2,822	2,823 3,360	3,361 +
	Weekly	0 388	389 516	517 651	652 775	776 +
4	Yearly	0 24,300	24,301 32,319	32,320 40,824	40,825 48,600	48,601 +
	Monthly	0 2,025	2,026 2,693	2,694 3,402	3,403 4,050	4,051 +
	Weekly	0 467	468 622	623 785	786 935	936 +
5	Yearly	0 28,440	28,441 37,825	37,826 47,779	47,780 56,880	56,881 +
	Monthly	0 2,370	2,371 3,152	3,153 3,982	3,983 4,740	4,741 +
	Weekly	0 547	548 727	728 919	920 1,094	1,095 +
6	Yearly	0 32,580	32,581 43,331	43,332 54,734	54,735 65,160	65,161 +
	Monthly	0 2,715	2,716 3,611	3,612 4,561	4,562 5,430	5,431 +
	Weekly	0 627	628 833	834 1,053	1,054 1,253	1,254 +
Add the following amounts for each additional family member over 6	Yearly	4,160	5,533	6,989	8,320	8,320
	Monthly	347	461	582	693	693
	Weekly	80	106	134	160	160

By signing below you are stating the information you have provided is true, and you authorize CCFHS to verify that information, and release it to referring/mutual providers of care. You acknowledge that you are financially responsible for the full balance of your charges if you are a self-pay; for the balance of your charges after any discount has been applied; and for any deductibles, co-pays or any services that your insurance does not cover. Failure to fulfill your financial responsibility to us or agree to a payment schedule may result in your financial discharge from our services.

_____ I do not wish to apply for the sliding fee scale or do not qualify for the sliding fee scale.

_____ I decline to provide financial information.

_____ I would like to apply for the sliding fee scale by completing an Application for Financial Assistance (must be completed within 30 days of appointment)

Patient Signature (or Responsible Party): _____ Date: _____

For Office Use Only:
Employee Signature: _____ Date:_____

Revised 07/2015, 05/2016