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, 2018

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	12,140	12,141	16,146	16,147	20,395	20,396	24,280	24,281	30,350
	Monthly	0	1,012	1,013	1,346	1,347	1,700	1,701	2,023	2,024	2,529
	Weekly	0	233	234	311	312	392	393	467	468	584
2	Yearly	0	16,460	16,461	21,892	21,893	27,653	27,654	32,920	32,921	41,150
	Monthly	0	1,372	1,373	1,824	1,825	2,304	2,305	2,743	2,744	3,429
	Weekly	0	317	318	421	422	532	533	633	634	791
3	Yearly	0	20,780	20,781	27,637	27,638	34,910	34,911	41,560	41,561	51,950
	Monthly	0	1,732	1,733	2,303	2,304	2,909	2,910	3,463	3,464	4,329
	Weekly	0	400	401	531	532	671	672	799	800	999
4	Yearly	0	25,100	25,101	33,383	33,384	42,168	42,169	50,200	50,201	62,750
	Monthly	0	2,092	2,092	2,782	2,783	3,514	3,515	4,183	4,184	5,229
	Weekly	0	483	484	642	643	811	812	965	966	1,207
5	Yearly	0	29,420	29,421	39,129	39,130	49,426	49,427	58,840	58,841	73,550
	Monthly	0	2,452	2,453	3,261	3,262	4,119	4,120	4,903	4,904	6,129
	Weekly	0	566	567	752	753	950	951	1,132	1,133	1,414
6	Yearly	0	33,740	33,741	43,874	43,875	56,683	56,684	67,480	67,481	84,350
	Monthly	0	2,812	2,813	3,740	3,741	4,724	4,725	5,623	5,624	7,029
	Weekly	0	649	650	863	864	1,090	1,091	1,298	1,299	1,622
Add the following amounts for each additional family member over 6	Yearly		4,320		5,746		7,258		8,640		10,800
	Monthly		360		479		605		720		900
	Weekly		83		110		140		166		208

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, 02/2017, 02/2018