



Patient Information

Date: _____

Legal Name: _____ Nickname: _____

Date of Birth: ___/___/___ Age: ___ Social Security Number: ___-___-___ Student: Yes No

Marital Status: Married Single Life Partner Divorced Widowed Gender: Male Female

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone Number: ___-___-___ Cell Phone: ___-___-___ **E-mail:** _____

Patient Employer: _____ Address: _____ Work Phone: ___-___-___

Spouses Name: _____ Date of Birth: ___/___/___ Social Security Number: ___-___-___

PREFERRED METHOD OF CONTACT:

TEXT CELL PHONE HOME PHONE EMAIL Other: _____

Who is your Primary Care Provider _____ **Who is your Primary Dental Provider:** _____

Who is your Primary Optometry Provider: _____

Would you like information regarding our Sliding Fee Program? Yes No

Responsible Party Information

Name: _____ Date of Birth: ___/___/___ Social Security Number: ___-___-___

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Address: _____ Work Phone: ___-___-___

Emergency Contact

Name: _____ Relationship: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone Number: ___-___-___ Cell Phone: ___-___-___ Work Phone: ___-___-___

Insurance Information

Primary Insurance Company: _____ Address: _____

ID Number: _____ Group Number: _____ Group Name or Employer: _____

Subscriber Name: _____ Date of Birth: ___/___/___ Subscriber Relation to Patient: _____

Secondary Insurance Company: _____ Address: _____

ID Number: _____ Group Number: _____ Group Name or Employer: _____

Subscriber Name: _____ Date of Birth: ___/___/___ Subscriber Relation to Patient: _____



ADAMS COUNTY HEALTH CENTER INC.
Working Together to Improve Lives in Our Communities

PATIENT CONSENT FORM

Patient Name: _____

Birth Date: ____/____/____

CONSENT FOR TREATMENT. I voluntarily consent to care and treatment by Adams County Health Center, Inc. (ACHC) and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, dental, therapeutic care, and nursing; diagnostic, laboratory, and radiological tests and procedures; and such other care as deemed reasonably necessary or advisable by the attending provider, practitioner or staff member. If ACHC personnel suffer a needle stick or are exposed to blood or body fluids, I consent to the testing for any blood-borne disease for the protection of ACHC personnel.

ADVANCE DIRECTIVES. Please indicate whether the Patient has executed an advance directive, e.g.:
 Living Will (A document outlining which medical treatments you desire or refuse if you are terminally ill or permanently unconscious.) Durable Power of Attorney (A legal document naming a person (surrogate/agent) to make medical decisions for you if you cannot communicate) POLST Other: _____

I have not executed an Advance Directive.
 I would like to be contacted to get more information

CONDITIONS FOR TREATMENT AT ACHC. In consideration for the care and treatment that I will receive or have received at ACHC, I agree to the following:

- 1. Patient Responsibilities.** I agree to comply with the Patient Responsibilities set forth in ACHC’s separate Notice of Privacy Practices, as well as those outlined within this consent.
- 2. Payment.** I agree that I am responsible for any co-payments, deductibles or other charges for services that are not paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and ACHC. I acknowledge payment for all department services rendered (clinic, lab, x-ray, behavioral health, physical therapy) is due at time of service, unless payment arrangements have been made with the Accounts Receivable Coordinator. There are no exceptions to this. Insurance is gladly billed as a courtesy to our patients when we are provided with current information. Acceptable forms of payment are: cash, personal or company check, credit or debit card (Visa or MasterCard only), personal money order or cashier’s check.
In the case of minor children, the adult who brings the child to his/her appointment is responsible for payment of the account.
- 3. Assignment.** I hereby assign and authorize direct payment to ACHC of any payments or other benefits to which I may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with care. I agree that this assignment will not be withdrawn or voided at any time until my account is paid in full. Please note, we cannot accept responsibility for collecting an insurance claim after 60 days, or for negotiating a disputed claim. Insurance reimbursement is a contract between the patient, their employer, and the insurance carrier.
- 4. Billing Practices.** I understand and agree that any quote of charges for services rendered and/or insurance benefits available are estimates based upon the best information available at the time. ACHC may amend such quotes and I will be responsible for charges for services actually rendered. Where insurance is available, ACHC will bill and allow a reasonable time for the insurance company to pay. I will be responsible for any amount not covered by insurance. Should payment not be received, I will be billed for all charges and interest. Payment is due upon receipt of the bill.

NO GUARANTEE. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results my care or treatment at ACHC.

PERSONS FOR WHOM ACHC IS NOT LIABLE. I understand that ACHC is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by ACHC may be involved in my care or treatment, including but not limited to independent contractors, vendors, or product technicians. I understand that ACHC is not liable for the acts or omissions of non-employees or ACHC employees acting outside the course and scope of their duties.



PREFERRED METHOD OF CONTACT:

I agree to be contacted by ACHC either by text, calling either a cell phone or home phone, or via email.

NOTICE OF PRIVACY PRACTICES.

I have received a copy of ACHC’s Notice of Privacy Practices on this or a prior occasion. [Please Initial]: _____

I have fully read, understand, and agree to this Consent, Conditions of Treatment, and Preferred Method of Contact. I certify that I am either the Patient or the Patient’s legally authorized representative and have authority to execute this Consent and Agreement on behalf of the Patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

(Print Name)

(Date)

(Signature)

Relationship to Patient/Authority

Consent to Allow Family Member or Other Person Involved in Care or Payment to Access Medical Information

The person(s) listed below are family members or others who are involved in the Patient’s health care or payment for health care. I give permission to Adams County Health Center (ACHC) to disclose the Patient’s protected health information to such persons. As the patient you may revoke this authorization to disclose information to the person(s) in writing and explain why you are revoking the authorization.

<u>Name:</u>	<u>Relationship:</u>	<u>Phone Number:</u>

In addition to the person(s) listed above, there are or may be other persons who are involved in the Patient’s health care or payment for health care. This consent is *not* intended to limit ACHC’s authority to disclose protected health information to such other persons to the extent allowed by applicable law, including but not limited to 45 CFR 164.510.

Signature

Date

If signed by a Personal Representative:

Print name of Personal Representative

State authority of Personal Representative or relationship to patient.



ACKNOWLEDGMENT OF PATIENT GRIEVANCE POLICY

The following is the Adams County Health Center Inc.’s Patient Grievance Policy. Please sign below to acknowledge that you have read this and have been given a copy of the ACHC Notice of Privacy Practices brochure.

PATIENT GRIEVANCE POLICY

If you feel that you have been denied a benefit or service due to your race, color, national origin, age, sex, disability, religious or political beliefs, or if you feel that your privacy/confidentiality has been violated, you may file a complaint with a member of the Executive Team of this facility in writing. A written response will be issued to you within 15 days of complaint notice. If you feel you need assistance you may also file a complaint with the U.S. Department of Health and Human Services or Idaho Department of Health and Welfare (see addresses below). Your complaint must be in writing, you must include your name, address, telephone number and a brief description of the incident. If you need assistance, a member of the Executive Team will be available to help. We will not retaliate or take action against you for filing a complaint.

Executive Team:
CEO: Mendy Stanford or CFO: Wendy Mott
Address: 205 N. Berkley, P.O. Box 428, Council, ID 83612
Telephone: 208-253-4242

Date: _____ Signature of Patient: _____
(or patient’s legal authorized representative)

U.S. Department of Health and Human Services
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

Approved: 09/23/09
Revised & Approved 01/27/10; 11/30/16; 02/23/2022;08/2023



Adams County Health Center Inc. - Patient Survey

Please take a moment to answer the questions below to help us in gathering data to comply with our Federally Qualified Health Center grant requirements.

All information that is collected on this form is for our Federal Funding at Adams County Health Center. Your information will remain confidential.

1.) **Please circle the Family Size and Monthly Income Level** that you fit into the best. The family size includes all residents in the household. The monthly income is for all residents of the household.

2026 MONTHLY INCOME LEVEL.

Family Size	Income	Income	Income	Income	Income	Income
1	\$ 1,330	\$ 1,663	\$ 1,995	\$ 2,328	\$ 2,660	\$2, 661
2	\$1,803	\$2,254	\$2,705	\$3,156	\$3,607	\$3,608
3	\$2,277	\$2,846	\$3,415	\$3,984	\$4,553	\$4,554
4	\$2,750	\$3,438	\$4,125	\$4,813	\$5,500	\$5,501
5	\$3,223	\$4,029	\$4,835	\$5,641	\$6,447	\$6,448
6	\$3,697	\$4,621	\$5,545	\$6,469	\$7,393	\$7,394
7	\$4,170	\$5,213	\$6,255	\$7,298	\$8,340	\$8,341
8	\$4,643	\$5,804	\$6,965	\$8,126	\$9,287	\$9,288
9	\$5,117	\$6,396	\$7,675	\$8,954	\$10,233	\$10,234
10	\$5,590	\$6,988	\$8,385	\$9,783	\$11,180	\$11,181

**If you refuse to answer the above question, please check here*

2.) **Are you a Veteran?** Yes NO (If you answered "Yes" please check all that apply)

Active Duty Active Reserve National Guard Retired

3) **What is your housing situation today?**

I have housing I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park) I choose not to answer.

4) **Please check the appropriate Race:**

White Native Hawaiian Pacific Islander Black/African American American Indian/Alaska Native
Asian Asian Indian Chinese Filipino Japanese Korean Vietnamese Guamanian or Chamorro Samoan
Choose not to disclose Other: _____

5) **Please check the appropriate Ethnicity:**

Not Hispanic or Latino Mexican, Mexican American, Chicano Puerto Rican Cuban Other Hispanic/Latino or Spanish origin Unknown/Not Reported *If you refuse to choose a race or ethnicity, please check here:*

6) **At any point in the past 2 years, has season or migrant farm work been your or your family' main source of income?**

Yes, Seasonal Yes, Migrant No I choose not to answer this.

Patient Name (**please print**): _____

Date: _____