SEMO HEALTH NETWORK

Patient Information Date ____/____/_____

_____ _____
First **Middle** **Last Name** **Date of Birth**

_____ _____-____-_____
Address **City** **State** **Zip** **Social Security Number**

_____
Mailing Address (if different than above)

Circle one:
Female
Female to Male/Transgender
Male
Male to Female/Transgender
Genderqueer (not male or female)
Other, _____
Refused to report

Contact Information

MAY WE LEAVE DETAILED MESSAGES
(Appointment, billing, results, etc?)

Home # ( ) Yes No N/A

Mobile # ( ) Yes No N/A

Work # ( ) Yes No N/A

_____ Yes No N/A
Email address (if you would like emails)

Emergency Contact

May we discuss your care with anyone else? Yes No N/A
(Concerning your medical care or billing.)

_____ _____ _____
First Middle Last Name Relationship Phone #

_____ _____ _____
First Middle Last Name Relationship Phone #

Marital Status **___Single ___Married ___Divorced ___Separated ___Widowed**

Sexual Orientation **____Bisexual ___Lesbian or Gay ___Straight ___Other_____ ___Unknown ___Refused to report**
(please specify)

Employment Status

__Full Time __Part Time __ None __Student __Retired __Disabled
Employer ____ _____Address_____

SEMO HEALTH NETWORK

Pharmacy Information

Name:			Address:	
City:	State:	Zip:	Phone:	Fax

Guarantor/Responsibility Party

Person responsible for bill : __ self (If self skip this section)		Relationship to patient __ Spouse __parent __Step parent __other _____	Birth date: / /	SSN: _____
Address (street, city, state, zip) same as patient		Primary Phone Number		
Occupation	Employer		Employer phone	

Medical Insurance Information (Please give your insurance card to the receptionist)

Fill out all that applies ___Insurance ___Medicare ___Medicaid ___Private pay ___Sliding fee (ask receptionist for details on applying)

Name of primary Insurance	Subscribers name	Social security number
Policy #	Group #	Subscribers Birth Date: / /
Subscriber's address __ same as patient	Subscriber's phone #	

Primary medical insurance relationship to the patient: ___self ___spouse ___parent ___step parent ___other_____

Name of secondary Insurance	Subscribers name	Social security number
Policy #	Group #	Subscribers Birth Date: / /

Secondary medical insurance relationship to the patient: ___self ___spouse ___parent ___step parent ___other_____

Payments

AS a courtesy, SEMO Health Network will file your insurance claim provided that you have given us the current/valid information about your insurance. I hereby authorize my benefits, including Medicare, to be paid directly to SEMO Health Network and also the release of medical information necessary to process claims. This assignment will remain in effect until revoked by me in writing. Applicable co-payments and deductible for those insurance plans will be collected. If insurance does not pay, I will become financially responsible for payment in full.

_____ _____

Signature of patient or responsible Party **Date**

SEMO HEALTH NETWORK

Demographics (1 of 2)

Affordable Healthcare Act Questionnaire

We are required to ask all patients, you may choose not to answer.

Ethnicity	**Race**	**Preferred Language**	**Housing Status**
(check only one)	**(check only one)**	**(check only one)**	__Not homeless
___ I choose not to answer	**___I choose not to answer**	**___English**	__Shelter
___Not Hispanic or Latino	**___American Indian/Alaskan Native**	**___Spanish**	__Public Housing
___Hispanic or Latino	**___Asian**		__Transitional
	___Black/African American		__Homeless Street
	___Native Hawaiian/Other Pacific Island		
	___White/Caucasian		
	___Other:_____		

Education Status

of Education years___ Level of school attended ___

Are you in school? ___Yes ___No If yes where? _____ **___**Full Time ___Part Time

Do you do agricultural work? __Yes __No

___Not agricultural worker ___Migrant Worker ___Dependent of Migrant worker

___Seasonal Worker ___Dependent of seasonal worker

Over the past 24 months (2 years) have you:

Been hired to do agricultural work as your main source of income? __Yes __No

Established temporary residence in order to do agricultural work? __Yes __No

Are you a United States Citizen? __Yes __No

Are you a Veteran? __Yes __No

How did you hear about SEMO Health Network

___School	___Hospital	___Bootheel Healthy Start	___DAEOC
___Health Department	___ Friend	___ Home Health	___Mission Missouri
___Family Member	___Private Physician	___ Local Business	___Media
___Chamber Of Commerce	___Family Services	___Probation Officer	___Other_____

Please list anyone allowed to be given your medical information:

1. _____
2. _____
3. _____
4. _____
5. _____

Your information will not be released by telephone or in person to anyone not on this list.

SEMO HEALTH NETWORK

Family Size and Income Please select the number of family who live in your home in the far left column. Then circle the income range for the entire household. (Same row as the family size)

☐	1	→	$0-12,060	$12,061-16,040	$16,041-20,020	$20,421-24,120	$24,121 & up
☐	2	→	$0-16,240	$16,241-21,599	$21,600-26,598	$26,959-32,480	$31,461 & up
☐	3	→	$0-20,420	$20,421-27,159	$27,160-33,897	$33,898--40,842	$40,843 & up
☐	4	→	$0-24,600	$24,601-32,718	$32,719-40,836	$40,837-49,202	$47,701 & up
☐	5	→	$0-28,780	$28,781-38,277	$38,278-47,775	$47,776-57,562	$57,562 & up
☐	6	→	$0-32,960	$32,961-43,837	$43,838-54,714	$54,715-65,922	$65,923 & up
☐	7	→	$0-37,140	$37,141-49,396	$49,397-61,652	$61,653-74,282	$72,061 & up
☐	8	→	$0-41,320	$41,321-54,956	$54,957-68,591	$68,952-82,642	$82,642& up

Privacy Acknowledgement

_____ Initial **We are required to protect your privacy.** Our Notice of Privacy Policy (NPP) details your rights as a patient and how we may use and/or disclose your protected health information. Our NPP is Available on our website at www.SEMOhealthnetwork.org and/or is furnished.

_____ **Initial** **We request all patients present photo ID and their insurance card at each visit.** Your cooperation with this HIPAA requirement is designed to protect your identity from misuse.

_____ **Initial** **HIPAA Security Rule establishes national standards to protect your health information.** You will need required personal information when calling our office regarding question's to your account.

_____ **Inital** **Patients may revoke or change any provided authorizations at any time.** Please refer to our NPP at www.SEMOhealthnetwork.org for more details.

Consent for Treatment – ADULT: By signing below I am giving consent to receive treatment or procedure deemed necessary by the professional staff of SEMO Health Network. I understand all the preceding statements and will adhere to the stated policies.

Consent for Treatment – CHILD or INCAPITATED ADULT: By signing below I hereby state that I am the parent, primary legal guardian, or joint legal custodian of the patient being presented today for treatment. I also am giving my consent as guardian for any treatment or procedure deemed necessary by the professional staff of SEMO Health Network. I understand all the preceding statements and will adhere to the stated policies.

_____ _____

Print Name of Patient Date

_____ _____

Patient/Legal Guardian Signature Date