WILLIAMSON HEALTH AND WELLNESS CENTER

PT ACCT#_____

Dear Patient: We are a non-profit clinic that provides low cost health care on a sliding scale. Visit costs for patients are determined by a sliding fee scale that is calculated based on income and household size. Due to new federal reporting regulations, the following information is now required for each patient. Please note that all information is confidential. We appreciate your cooperation with these new reporting requirements and will need to collect this information on an annual basis

Patient Information:

Last Name_____ First Name_____ Initial___

Date of Birth_____ SS#_____

Mailing Address: _____City, State, Zip _____

Home Phone:_____ Mobile Phone:_____

Email Address:_____@_____

Living Arrangements: (please check one)

□ **Shelter** (safe havens, temporary overnight housing, armories) □ **Transitional** (center, community, home) □ **Other** (hotel, motel, day-to-day single room occupancy) □ **Doubling Up** (living with other people for a temporary period and move often) □ **Street** (sidewalk, car, park, doorway, public or abandoned building) **Permanent Residence** ___ own or ___rent

Ethnic Origin: (please check one) Hispanic: ☐ Yes ☐ No

Race: (please check all that apply) ☐ Caucasian ☐ Latino ☐Asian ☐ Pacific Islander

☐ Native Hawaiian ☐ Black or African American ☐ American Indian/Alaskan Native

☐ Other/Choose Not to Disclose

Gender Identity: ☐ Male ☐ Female ☐Transgender Male/Female-to-Male

☐ Transgender Female/Male-to-Female ☐ Choose Not to Disclose ☐ Other

Sexual Orientation: ☐ Straight ☐Bisexual ☐ Don't Know ☐ Lesbian or Gay

☐ Something Else ☐ Choose Not to Disclose

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse or Parent/Guardian Information (if applicable):

Last Name:_____ First Name:_____ DOB:_____

Work Phone:_____ Cell Phone:_____

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Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information (PHI) be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must provide an alternative address or other method of contacting you. Some method of contact must be provided.

This request supersedes any prior request for communication of information submitted prior to the date below.

Extended Authorization Please list any persons you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker or other family member:

Name (First and Last)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Restrictions on Communication Methods Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below any ways in which you do NOT want to receive communications:

□ No calls to phone number(s): _____
□ No messages or voice mails left on phone number(s): _____
□ No mail to the following address(es): _____ □
□ Patient Portal □ Other (please specify):

_____ _____
Signature of Patient/Responsible Party Date

Pharmacy _____

PATIENT PRE-SCREENING QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy.

1. Have you traveled in the past 30 days? YES or NO

2. Have you been in close contact with confirmed Covid-19 case? YES or NO

IN THE LAST 48 HOURS:

- Have you had a fever (99.5°+)? YES or NO
- Resent/new onset cough (not related to allergy or COPD) YES or NO
- Recent/new onset Sore Throat (not related to allergy) YES or NO
- Recent/new onset shortness of breath (not related to chronic disease) YES or NO
- Muscle Aches? YES or NO
- Stomach Pain? YES or NO

Print Name: _____

Signature: _____ Date: _____

****Please return this form to the front desk when completed****

Staff Initials: _____

WILLIAMSON HEALTH AND WELLNESS CENTER

Effective 1/1/2022

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

* Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [304-236-5902 Ext. 1402].

Patient Signature _____ Date of Birth_____

Signature Date_____