



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Honor Community Health may use and disclose protected health information (PHI) about me to carry out Treatment, Payment, and Operations (TPO). Please refer to Honor Community Health's Notice of Privacy Practices posted in the clinic for a more complete description of such uses and disclosures.

Honor Community Health observes the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Honor Community Health at 461 W. Huron, Pontiac, MI 48341-1601.

With my consent, Honor Community Health may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

Honor Community Health may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

Honor Community Health may email or text me appointment reminders and patient statements. I have the right to request that Honor Community Health restrict how it uses or discloses my PHI to carry out the TPO. However, the center is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Honor Community Health's use and disclosure of my PHI to carry out TPO. I understand that I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance to my prior consent. If I do sign the consent, Honor Community Health may decline to provide treatment to me.

I consent to the person(s) listed below having access to my entire Personal Health Information (PHI). I also authorize Honor Community Health to talk about my entire PHI to the person(s) listed below:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I give permission to the individual listed below to bring my children to their healthcare appointments and pick-up medication from the pharmacy:

Name: _____ Relationship: _____ Phone #: _____

X _____
Signature of Patient or Patient's Legal Guardian (if applicable)

Date

Print Patient's Name

Print Name of Patient's Legal Guardian (if applicable)



Live healthy. Be well.

CONSENT FOR TREATMENT

I hereby consent to all treatment, including tests, evaluation, procedures, and medications deemed necessary by the clinicians and staff of Oakland Integrated Healthcare Network (OIHN) DBA Honor Community Health.

I understand clinicians and staff will depend on statements I make, information in my health history, and other information as available to evaluate my condition and decide on the best treatment.

I understand that clinicians and staff will discuss the benefits and risks of treatment with me, and that I can ask questions about my treatment or the protection of my health records at any time.

I understand that I have the right to refuse any procedure or treatment.

I understand that OIHN maintains an integrated health record which contains health information regarding all of the services I receive from OIHN (medical, behavioral health, substance use, dental, etc.). Any OIHN clinician or staff member I interact with will have access to my integrated health record, this includes any applicable substance abuse treatment records.

I understand that some services at OIHN may be provided using telemedicine equipment and involve interactions with providers who are not physically present for my appointment. These sessions are transmitted via a secure, dedicated connection and are not: videotaped, routed through the internet, recorded, or saved in any way. However, relevant information will be documented in my health record, just as it would be if the provider had been physically present. I understand that at any point I can decide that telemedicine sessions are not meeting my needs and request an in-person appointment.

I agree to pay any charges at the time of service or upon receipt of statement.

I understand that this consent shall remain valid for a period of one year from the date below unless I withdraw consent, or the program has already acted on it. All consents must be withdrawn in writing with the exception of consent for substance abuse treatment which can be withdrawn verbally.

I agree that I have been provided adequate information and the chance to have questions answered.

X _____
Signature of Patient or Patient's Legal Guardian (if applicable)

Date

Print Patient's Name

Print Name of Patient's Legal Guardian (if applicable)



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PATIENT INTAKE FORM

Thank you for selecting us. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)						
Today's Date		Last Name		First Name		
Date of Birth		Social Security Number				
Street Address				Apartment/Unit #		
City		State		Zip Code		
Home Phone		Work Phone		Cell Phone		
Parent/Guardian Name			Relationship?			
May we text you with appointment reminders and information regarding your healthcare? <small>*Standard data fees & text message rates may apply based on your mobile phone carrier</small>					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Email				Can we use your email for Patient Portal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				Can we email you information?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gender at Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Current Gender	<input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (Female to Male) <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female (Male to Female) <input type="checkbox"/> Other <input type="checkbox"/> Choose not to Disclose			
Sexual Orientation	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Something Else <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Don't Know <input type="checkbox"/> Bisexual <input type="checkbox"/> Choose not to Disclose	Preferred Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			
Race	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Refuse to Report					
Ethnicity	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Refuse to Report					
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Military Status	<input type="checkbox"/> Activity Duty <input type="checkbox"/> Retired <input type="checkbox"/> Veteran					
Employment Status	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Student					
Employer				Occupation		
Preferred Pharmacy	Pharmacy Name					
	Pharmacy Address					
	Pharmacy Phone Number					
Advance Directive	Do you have an Advanced Directive? <small>(Your wishes regarding your medical treatment in case of an emergency)</small>				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If No, would you like more information on them?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Agricultural Work	<input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> Full Time					

Living Situation	<input type="checkbox"/> I own/rent a home/apartment/condo <input type="checkbox"/> Transitional Housing (I have been homeless in the past year, but have housing now/ staying in a treatment facility) <input type="checkbox"/> Doubling Up (Staying with friends/relatives because I have no other choice) <input type="checkbox"/> Staying in a Shelter (Short term housing such as HOPE, SOS, Haven etc.) <input type="checkbox"/> Street (Living outdoors or in a car/camper) <input type="checkbox"/> Other Homeless (Living somewhere not meant to be a home – no running water or heat etc.)	
	Are you worried about losing your housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you receive services from any of the following agencies?	<input type="checkbox"/> Community Network Services (CNS)	<input type="checkbox"/> Training and Treatment Innovations (TTI)
	<input type="checkbox"/> Easter Seals (ES)	<input type="checkbox"/> Community Living Services (CLS)
	<input type="checkbox"/> Oakland Family Services (OFS)	<input type="checkbox"/> Community Housing Network (CHN)
	<input type="checkbox"/> Common Ground	<input type="checkbox"/> Macomb Oakland Regional Center (MORC)
	<input type="checkbox"/> Oakland Livingston Human Services (OLHSA)	<input type="checkbox"/> None

How did you hear about us?	<input type="checkbox"/> Billboard <input type="checkbox"/> Social Media <input type="checkbox"/> Website <input type="checkbox"/> Commercial <input type="checkbox"/> Family/Friend <input type="checkbox"/> Other: _____
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Emergency Contact

Name		Relationship	
Home Phone		Cell Phone	

Current Healthcare Provider

Do you have a previous Medical Provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please list: _____
Do you have a Dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please list: _____

Health History: Have you or any blood relative had: (please write who was diagnosed i.e., brother, sister, aunt, uncle, children)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Myself	Relative: _____
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Myself	Relative: _____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> HIV	<input type="checkbox"/> Myself	Relative: _____
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> Drug Use	<input type="checkbox"/> Myself	Relative: _____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> Colorectal Cancer	<input type="checkbox"/> Myself	Relative: _____
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> Rectal Polyps	<input type="checkbox"/> Myself	Relative: _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Myself	Relative: _____
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Myself	Relative: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> Other	<input type="checkbox"/> Myself	Relative: _____
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Myself	Relative: _____	<input type="checkbox"/> Other	<input type="checkbox"/> Myself	Relative: _____

Honor Cares: Sliding Fee Program

Honor Community Health offers discounted fees for qualified patients who may be unable to pay the full fee for services. As a non-profit organization, we receive funding from local, state, federal and grant funding sources and we are required to collect financial information from our patients to continue to receive this funding. All information will remain confidential.

Slide Category	A	B	C	D	E					
	<p>Locate the row describing your family size and then circle the corresponding Total Household Income Range</p> <p>Example for 3 person household with \$30,000 total income:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 5px;">3 people living in household annually earning:</td> <td style="padding: 5px;">\$0 to \$21,720</td> <td style="padding: 5px; border: 2px solid blue;">\$21,721 to \$32,580</td> <td style="padding: 5px;">\$32,581 to \$38,010</td> </tr> </table>						3 people living in household annually earning:	\$0 to \$21,720	\$21,721 to \$32,580	\$32,581 to \$38,010
3 people living in household annually earning:	\$0 to \$21,720	\$21,721 to \$32,580	\$32,581 to \$38,010							
Family Size: Count Adult and Children	Total Household Income Range									
1 person living in household annually earning:	\$0 to \$12,760	\$12,761 to \$19,140	\$19,141 to \$22,330	\$22,331 to \$25,520	\$25,761 to \$31,900	\$31,901+				
2 people living in household annually earning:	\$0 to \$17,240	\$17,241 to \$25,860	\$25,861 to \$30,170	\$30,171 to \$34,480	\$34,481 to \$43,100	\$43,101+				
3 people living in household annually earning:	\$0 to \$21,720	\$21,721 to \$32,580	\$32,581 to \$38,010	\$38,011 to \$43,440	\$43,441 to \$54,300	\$54,301+				
4 people living in household annually earning:	\$0 to \$26,200	\$26,201 to \$39,300	\$39,301 to \$45,850	\$45,851 to \$52,400	\$52,401 to \$65,500	\$65,501+				
5 people living in household annually earning:	\$0 to \$30,680	\$30,681 to \$46,020	\$46,021 to \$53,690	\$53,691 to \$61,360	\$61,361 to \$76,700	\$76,701+				
6 people living in household annually earning:	\$0 to \$35,160	\$35,161 to \$52,740	\$52,741 to \$61,530	\$61,531 to \$70,320	\$70,321 to \$87,900	\$87,901+				
7 people living in household annually earning:	\$0 to \$39,460	\$39,461 to \$59,460	\$59,461 to \$69,370	\$69,371 to \$79,280	\$79,281 to \$99,100	\$99,101+				
8 people living in household annually earning:	\$0 to \$44,120	\$44,121 to \$66,180	\$66,181 to \$77,210	\$77,211 to \$88,240	\$88,241 to \$110,300	\$110,301+				
More than 8 people living within the household:	\$4,480									

I confirm that the above information is truthful and accurate. I agree to inform Honor Community Health of any changes in my income. Failure to provide truthful, accurate and/or timely information may result in loss of funding for sliding fee scale privileges.

I refuse to apply for the Honor Cares Sliding Fee Program

X _____
Signature of Patient or Patient's Legal Guardian (if applicable)

Date

Print Name of Patient's Legal Guardian (if applicable)