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)

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 with 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)

HONOR Community HEALTH
Live healthy. Be well.

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? *Standard data fees & text message rates may apply based on your mobile phone carrier					☐ Yes	☐ No
Email		Can we use your email for Patient Portal?			☐ Yes	☐ No
		Can we email you information?			☐ Yes	☐ No
Gender at Birth	☐ Female ☐ Male	Current Gender	☐ Female ☐ Male ☐ Other	☐ Transgender Male (Female to Male) ☐ Transgender Female (Male to Female) ☐ Choose not to Disclose		
Sexual Orientation	☐ Straight/Heterosexual ☐ Lesbian or Gay ☐ Bisexual	☐ Something Else ☐ Don't Know ☐ Choose not to Disclose		Preferred Language	☐ English ☐ Spanish ☐ Other: _____	
Race	☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander	☐ Asian ☐ White/Caucasian		☐ Black/African American ☐ Refuse to Report		
Ethnicity	☐ Hispanic/Latino	☐ Not Hispanic/Latino		☐ Refuse to Report		
Marital Status	☐ Single	☐ Married	☐ Partner	☐ Separated	☐ Divorced	☐ Widowed
Military Status	☐ Activity Duty	☐ Retired		☐ Veteran		
Employment Status	☐ Full Time	☐ Part Time	☐ Unemployed	☐ Disabled	☐ Retired	☐ Student
Employer			Occupation			
Preferred Pharmacy	Pharmacy Name					
	Pharmacy Address					
	Pharmacy Phone Number					
Advance Directive	Do you have an Advanced Directive? (Your wishes regarding your medical treatment in case of an emergency)				☐ Yes	☐ No
	If No, would you like more information on them?				☐ Yes	☐ No
Agricultural Work	☐ Migrant	☐ Seasonal		☐ Full Time		

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

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

How did you hear about us?	☐ Billboard ☐ Social Media ☐ Website ☐ Commercial ☐ Family/Friend ☐ Other: _____

Emergency Contact

Name		Relationship	
Home Phone		Cell Phone	

Current Healthcare Provider

Do you have a previous Medical Provider?	☐ Yes ☐ No	If Yes, please list:
Do you have a Dentist?	☐ Yes ☐ 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)

☐ Diabetes	☐ Myself	Relative: _____	☐ Mental Illness	☐ Myself	Relative: _____
☐ Blood Clots	☐ Myself	Relative: _____	☐ Hepatitis	☐ Myself	Relative: _____
☐ High Blood Pressure	☐ Myself	Relative: _____	☐ HIV	☐ Myself	Relative: _____
☐ Kidney Disease	☐ Myself	Relative: _____	☐ Drug Use	☐ Myself	Relative: _____
☐ Heart Disease	☐ Myself	Relative: _____	☐ Colorectal Cancer	☐ Myself	Relative: _____
☐ Lung Disease	☐ Myself	Relative: _____	☐ Rectal Polyps	☐ Myself	Relative: _____
☐ Cancer	☐ Myself	Relative: _____	☐ Tuberculosis	☐ Myself	Relative: _____
☐ Epilepsy	☐ Myself	Relative: _____	☐ Osteoporosis	☐ Myself	Relative: _____
☐ Arthritis	☐ Myself	Relative: _____	☐ Other	☐ Myself	Relative: _____
☐ Alcoholism	☐ Myself	Relative: _____	☐ Other	☐ 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
	Locate the row describing your family size and then circle the corresponding Total Household Income Range Example for 3 person household with $30,000 total income: 3 people living in household annually earning: | $0 to $23,030 | $23,031 to $34,545				
Family Size: Count Adult and Children	Total Household Income Range				
1 person living in household annually earning:	$0 to $13,590	$13,591 to $20,385	$20,386 to $23,782	$23,783 to $27,180	$27,181+
2 people living in household annually earning:	$0 to $18,310	$18,311 to $27,465	$27,466 to $32,042	$32,043 to $36,620	$36,621+
3 people living in household annually earning:	$0 to $23,030	$23,031 to $34,545	$34,546 to $40,302	$40,303 to $46,060	$46,061+
4 people living in household annually earning:	$0 to $27,750	$27,751 to $41,625	$41,626 to $48,562	$48,563 to $55,500	$55,501+
5 people living in household annually earning:	$0 to $32,470	$32,471 to $48,705	$48,706 to $56,822	$56,823 to $64,940	$64,941+
6 people living in household annually earning:	$0 to $37,190	$37,191 to $55,785	$55,786 to $65,082	$65,083 to $74,380	$74,381+
7 people living in household annually earning:	$0 to $41,910	$41,911 to $62,865	$62,866 to $73,342	$73,843 to $83,820	$83,821+
8 people living in household annually earning:	$0 to $46,630	$46,631 to $69,945	$69,946 to $81,602	$81,603 to $93,260	$93,261+
More than 8 people living within the household:	$4,670	$7,005	$8,172	$9,340	$9,341+

What is your income?	$_____	How often do you collect this income?	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Annually

☐ 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 decline 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)