Live healthy. Be well.

ANNUAL PATIENT UPDATE FORM

Patient Information

Last Name		First Name		Middle	
MRN		Date of Birth		Social Security #	
Street Address				Apt/Unit #	
City		State		Zip Code	
Cell Phone		Home Phone		Email Address	
Emergency Contact		Emergency Contact Phone			
Sex	☐ Female ☐ Male ☐ Choose not to disclose				
Race		Ethnicity			
Preferred Language	☐ English ☐ Spanish ☐ Other: ___________________________				
Marital Status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Choose not to disclose				
Have you served in the US military?	☐ Yes ☐ No				

Guarantor Information (If Different Than Above)

Guarantor Name		Guarantor Relationship	
Guarantor Cell Phone		Guarantor Home Phone	
Guarantor Street Address		Guarantor Apt/Unit #	
Guarantor City		Guarantor State	
		Guarantor Zip Code	

Primary Insurance Information

Insurance Company		Insurance Address					
Subscriber Name		Subscriber Date of Birth					
Relation to Subscriber		Policy #		Group #		Co-Pay $	

Secondary Insurance Information *(If applicable)*

Insurance Company		Insurance Address					
Subscriber Name		Subscriber Date of Birth					
Relation to Subscriber		Policy #		Group #		Co-Pay $	

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.)

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

I hereby consent to all treatments, including tests, procedures and medications as deemed necessary by the clinician staff of Honor Community Health HCH. I authorize the release of any information necessary for my ongoing care or to process any insurance claims related to my care. I agree to pay any charges at the time of service or upon receipt of statement. I grant permission for third party auditors to view my private health information as part of Honor Community Health's quality improvement and evaluation process. I understand that some services 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 recorded or videotaped in any way. I understand that at any point I can decide to request an in-person appointment.

Patient Signature: ____ Today's Date: __________________________

HONOR CARES DISCOUNT PROGRAM APPLICATION

All information is confidential and used for internal purposes only.

At Honor Community Health, we provide healthcare services to everyone, regardless of your ability to pay. We also offer a discount based on your household size and income. If you qualify, the discount will be applied to services at Honor, including lab tests. **Major dental services are not included in the discount program*

To continue participating in the discount program, you are required to complete a new application every year and provide proof of your income. This helps us make sure we are giving you the right discount you are getting the right benefits. Acceptable Proof of Income documents can be:

- **Paycheck stubs or direct deposit statements**
- **Disability payments (W2, check stubs)**
- **Tax documents (Tax return, W2, 1099)**
- **SSI Declaration page (SSA109**

Complete the following information, even if you have insurance.

***You may be eligible for a discount even if you have insurance.*

1 Household Size: *How many people live with you that share expenses?*

Household Member	Number
You	1
Spouse or Partner	
Dependent Children	
Other Dependents	

2 Household Income: *What is your income before taxes and deductions? If you or a household member have no income, write $0.*

Household Member	Income	How are you paid? Check ONE
You	$	☐Weekly ☐Monthly ☐Yearly
Spouse or Partner	$	☐Weekly ☐Monthly ☐Yearly
Dependent Children	$	☐Weekly ☐Monthly ☐Yearly
Other Dependents	$	☐Weekly ☐Monthly ☐Yearly

Check only ONE:

☐ I **AGREE** to apply for the Honor Cares Discount program and confirm that the information above is true and correct. I agree to tell Honor Community Health about any changes in my income. If I do not give true, correct, or timely information, I will lose my discount

OR

☐ I **DECLINE** to apply for the Honor Cares Discount Program

PRINT Name of Patient or Patient's Legal Guardian ______________________________ Patient's Date of Birth ___________________

SIGNATURE of Patient or Patient's Legal Guardian ___________________________________ Today's Date _____________________

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OFFICE STAFF ONLY

Was proof of income provided? ☐ Yes ☐ No

-------> If so, does it match what patient documented above? ☐Yes ☐ No ☐ N/A

Document the amount entered in Nextgen: $ ____________

Signature of Employee ***(who reviewed and entered information)*** _____________________ **Today's Date**_______________

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). I hereby acknowledge I have been offered or received Honor Community Health's Notice of Privacy Practices and that I may obtain a copy of the Notice of Privacy Practices at any time and that a copy of the Notice is posted in the Health Center.

Honor Community Health reserves 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 461W. Huron, Pontiac, MI 48341-1601.

With my consent, Honor Community Health may call my home or other designated location using contact information that I provide 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 if 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 Health Center is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

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 #: ________________________

PRINT Name of Patient _____________________________________ Today's Date _______________________________

SIGNATURE of Patient or Patient's Legal Guardian ____

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