

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: <i>How many people live with you that share expenses?</i>
Household Member	Number
You	1
Spouse or Partner	
Dependent Children	
Other Dependents	



2	Household Income: <i>What is your income before taxes and deductions? If you or a household member have <u>no income</u>, write \$0.</i>	
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) _____



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 (HCH).

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 at any time.

I understand that HCH maintains an integrated health record which contains health information regarding all the services I receive from HCH (medical, behavioral health, substance use, dental, etc.). Any HCH 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 I may receive services at HCH through telemedicine services. The limitations of telemedicine services include interactions with providers who are not physically present and involve the possibility of not being able to pick up conditions found during a complete physical exam. 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 clinician 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 a statement. I am entitled to request a Good Faith Estimate at each visit or if anticipated charges will exceed \$400. For more information regarding the Good Faith Estimate,

I am entitled to speak with an Honor Community Health staff member.

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 except for consent for substance abuse treatment which can be withdrawn verbally.

I understand that the practice of medicine is uncertain. It is impossible to avoid certain risks and clinical outcomes may be different for each patient.

Assignment of Medical Benefits:

- I authorize my insurance to pay Honor Community Health for all services rendered
- I understand that if I do not assign medical benefits, I may be billed the full cost of services rendered
- I understand that I may be responsible for co-payments, co-insurance and deductibles

For any reproductive health services received, I attest the following:

- A. I am freely requesting the use of these services. I have not been coerced (pressured or intimidated) to accept reproductive health services, use any specific method of birth control, or choose a specific option if I am pregnant. My consent to reproductive health services is not being used as a prerequisite or requirement to be eligible for any other service or assistance in other programs.
- B. I understand that all information shared is considered confidential and will not be disclosed without written authorization, unless otherwise required by law such as child abuse or neglect, protection of vulnerable adults, communicable disease reporting, or if a life-threatening condition is suspected.
- C. I have been given the option to receive confidential services.

- D. If I am billed through insurance for my care, I understand there could be a receipt of my visit disclosed to the insurance policy holder.

PRINT Name of Patient _____ Today's Date _____

SIGNATURE of Patient or Patient's Legal Guardian _____

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



NEW PATIENT INTAKE FORM

To help us meet all your healthcare needs, complete this form in ink.

If you have any questions or need assistance, please ask a staff member and we will be happy to help.

Patient Information					
Last Name			First Name		
Date of Birth			Social Security #		
Street Address				Apt/Unit #	
City		State		Zip Code	
Cell Phone		Home Phone		Work Phone	
Parent / Guardian Name <i>**If applicable</i>				Relationship to Parent / Guardian <i>**If applicable</i>	
May we text you with appointment reminders and information regarding your care? <i>*Standard data fees & text message rates may apply based on your mobile phone carrier</i>				☐ Yes ☐ No	
Email Address			Can we use your email for Patient Portal?		☐ Yes ☐ No
			Can we email you information?		☐ Yes ☐ No
Sex	☐ Female ☐ Male ☐ Choose not to disclose				
Race	☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Black/African American ☐ More than one race ☐ Hispanic/Latino ☐ Not listed/Choose not to disclose ☐ Middle Eastern/North African				
Ethnicity	☐ Mexican, Mexican American, Chicano/a ☐ Japanese ☐ Cuban ☐ Korean ☐ Puerto Rican ☐ Vietnamese ☐ Guamanian/Chamorro ☐ More than one ethnicity ☐ Asian Indian ☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Chinese ☐ Another Asian ethnicity ☐ Filipino ☐ Not listed/Choose not to disclose				
Marital Status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Choose not to Disclose				

Have you served in the US military?		☐ Yes ☐ No	
Preferred Pharmacy Name		Pharmacy Phone#	
Preferred Pharmacy Address			
Advance Directive	Do you have an Advanced Directive? (Your wishes for medical care if you become unable to communicate)		☐ Yes ☐ No
	If not, would you like more information on Advance Directives?		☐ Yes ☐ No

Insurance Information			
Do you have Health Insurance?	☐ Yes ☐ No	FOR DENTAL VISITS ONLY – Do you have Dental Insurance?	☐ Yes ☐ No
Health Insurance Company			
Who is the insurance subscriber/policy holder?	☐ Myself ☐ Parent ☐ Spouse/Partner ☐ Other _____		
Subscriber Name <i>**If other than you</i>		Subscriber Name Date of Birth <i>**If other than you</i>	
Policy Number		Group ID/Number	
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 ☐ Oakland Family Services (OFS) ☐ Community Housing Network (CHN) ☐ Oakland Livingston Human Services (OLHSA) ☐ Community Living Services (CLS) ☐ Training and Treatment Innovations (TTI) ☐ Community Network Services (CNS) ☐ None ☐ Easterseals MORC (ESM)		

Current Healthcare Provider Information	
Do you have a current Medical Provider?	☐ Yes ☐ No If yes, please list name(s): _____
Do you have a Dentist?	☐ Yes ☐ No If yes, please list name(s): _____
Emergency Contact	

Name		Relationship to you	
Cell Phone		Home Phone	

Patient Name: _____ Patient Date of Birth: _____

Today's Date: _____