Eau Claire Cooperative Health Center
People in Care do better.

Patient Information

Please print clearly and complete all sections that apply

Patient's Name: _____
(Last) (First) (MI)

Date of Birth: _____ **Sex**: _____ **SS#**: _____
(Month/Day/Year)

Address: _____
(Street) (Apt #) (Lot)

City: _____ State: _____ Zip: _____ County: _____

Phone Home: _____ Cell: _____ Work: _____

Do you consent to receive text messages? □ Yes □ No

First Contact Preference: □ Home Phone □ Work Phone □ Mobile Phone □ Portal □ US Mail

Please check your Communications Preferences for the following (you may select multiple):

Appointments:	□ Email	□ Phone	□ Text message
Announcements:	□ Email	□ Phone	□ Text message
Health Notifications:	□ Email	□ Phone	□ Text message
Billing:	□ Email	□ Phone	□ Text message

Do you consent to receive Announcements & Health Notifications emails? □ Yes □ No

Patient Portal: Do you want to register for the Patient Portal? □ Yes □ Already Registered □ No

If **No** *select reason:* □ No Email □ No Internet □ Do not want to provide email □ Do not want portal account

If you wish to register for the portal you must provide your valid email address

Email Address: _____

Do you want to receive Patient Care Summaries (yours or your child's) through the Portal? □ Yes □ No

If portal access/email address is for an individual other than the patient, such as a parent or legal guardian:

Account Holder's Name: _____ Relationship to Patient: _____

Preferred Language of Communication_____

Marital Status: □ Single □ Married □ Life Partner □ Separated □ Divorced □ Widowed

Race: (Check all that Apply) □ American Indian or Alaskan Native □ Asian □ Pacific Islander
□ Black or African American □ Native Hawaiian □ Caucasian (White) □ Decline to answer

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino □ Decline to Answer

Patient Sexual Orientation: □ Straight or heterosexual □ Lesbian, gay or homosexual □ Bisexual
□ Don't Know □ Choose to not disclose

Gender Identity: □ Male □ Female □ Transgender Male/Female-to-Male □ Gender Queer
□ Transgender Female/Male-to-Female □ Choose to not disclose

Employer: _____ **Phone #:** _____

Occupation: _____ Industry: _____

Preferred Pharmacy: □ ECCHC In-House Pharmacy or □ Other: _____

Address/Phone #: _____

Preferred Primary Provider: _____

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If patient is a minor (under 18) please fill out the following area

Child's Place of Birth: _____
City State Country

Father's Name: _____ Phone Number: _____

Father's Employer: _____

Mother's Name: _____ Phone Number: _____

Mother's Maiden Name: _____

Mother's Employer: _____

Student Status: □ Full-time □ Part-time □ Not in School/Daycare Patient Speaks English: □ Yes □ No

Are there any custodial issues that impact authorization of medical care? □ Yes □ No
If yes, please explain and provide documentation: _____

_____

Is Patient:

Homebound:	□ Yes	□ No	□ Decline to answer
Veteran:	□ Yes	□ No	□ Decline to answer
Migrant Worker:	□ Yes	□ No	□ Decline to answer
Dependent of Agricultural Migrant Worker:	□ Yes	□ No	□ Decline to answer
Seasonal Worker:	□ Yes	□ No	□ Decline to answer
Dependent of Agricultural Seasonal Worker:	□ Yes	□ No	□ Decline to answer
Living in Public Housing or Section 8:	□ Yes	□ No	□ Decline to answer

Homeless: □ Doubling Up □ Street □ Transitional □ Homeless Shelter □ Unknown
□ No □ other: _____ □ Decline to answer

In Need of Transportation Services to Your Appointment with Us: □ Yes □ No □ Decline to answer

Patient's Guardian Name: _____
(Last) (First) (Middle)

Emergency Contact Name: _____

Relationship to Patient: _____ Home Phone: _____ Mobile Phone:_____

Please check all that apply in reference to the Emergency Contact: □ Healthcare Proxy □ Primary Caregiver
□ Patient Resides with Contact □ Release

Patient's Next of Kin Name: _____

Relationship to Patient: _____ Home Phone: _____ Mobile Phone:_____

Guarantor's Name: _____
(Last) (First) (Middle)

Relationship to Patient: _____ DOB: _____ SS# _____
(Month/Day/Year)

Address: _____
(Street) (Apt #) (Lot)

City: _____ State: _____ Zip: _____

Phone _____ Email: _____

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Primary Insurance to File:	**Secondary Insurance to File:**
Policy #: _____	Policy #: _____
Group #/Group Name: _____	Group #/Group Name: _____
Subscriber's Name: _____	Subscriber's Name: _____
Subscriber Date of Birth: _____ (Month/Day/Year)	Subscriber Date of Birth: _____ (Month/Day/Year)
Subscriber's SSN or ID #: _____	Subscriber's SSN or ID #: _____
Relationship to Patient: _____	Relationship to Patient: _____
Subscriber's Address: _____	Subscriber's Address: _____
_____	_____
Subscriber's Employer: _____	Subscriber's Employer: _____
Employer Address: _____	Employer Address: _____
_____	_____
Insurance Company Name: _____	Insurance Company Name: _____
Insurance Address: _____	Insurance Address: _____
_____	_____
Insurance Phone: _____	Insurance Phone: _____

Income: As a Federally Qualified Health Center (FQHC) we are *required by Federal law* to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is not reported or disclosed.

Household Size: _____ □ Decline to answer Household Income: _____ □ Decline to answer

Frequency: □ Daily □ Weekly □ Bi-Weekly □ Monthly □ Bi-Monthly □ Annually

How did you hear about us?

□ Advertising □ Community Seminar/Event □ Hospital □ Insurance Company □ Internet Search/Website
□ Mail □ Patient (in the Practice) Recommended □ Patient Resource Center Brochure □ Yellow Pages
□ Primary Care Physician □ Saw the Facility □ Social Media □ Specialist Physician □ Word of Mouth

Authorization to Treat and/or Discuss Treatment, Results, Procedures and Rx/Meds Pickup

This allows others to bring your child into the office and/or receive results or follow-up instructions.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR (OR YOUR CHILD'S) MEDICAL CONDITION? IF YES, WHOM?

The patient may revoke or modify an authorization with regard to any family member or other individual designated by the patient in the authorization. The revocation or modification must be in writing.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Information

Please print clearly and complete all sections that apply

Communications Notices. Please initial:

_____ Emails are generated through a secure facility, but are sent via a public network to a personal email address and as such may not be secure. I agree to advise the practice if my email address changes.

_____ Text messages are generated using a secure facility, but are transmitted over a public network onto a personal telephone and may not be secure. ECCHC will not transmit information that would enable an individual patient to be identified. I understand that I may have charges on my phone bill for messages received depending on my cell phone carrier & plan. I agree to advise the practice if my mobile number changes or is no longer in my possession.

_____ Appointment reminders by text are an additional service and may not be sent on all occasions. I am still responsible for attending appointments or cancelling them.

_____ I may change my communications preferences at any time. I may cancel my consent to communicate electronically or by text at any time by notifying the practice in writing.

_____ For pediatric patients: On the patient's age of majority birthday, athenaNet automatically changes the access level for the patient record for all family members from full access to billing-only. The practice or the patient can subsequently change family member's access level or remove access at any time.

Please respond:

1. Do you/Patient have Advance Directives (Living Will)? □ Yes □ No
   If yes, please provide the staff with a copy
2. Did you receive a Notice of Privacy Practices? □ Yes □ No
3. Did you receive, and agree to abide by, ECCHC's Patient's Rights and Responsibilities? □ Yes □ No
4. Do you give ECCHC permission to download the Patient's medication history automatically? □ Yes □ No
5. Do you give ECCHC permission to submit data to CARES-IS (Immunization Registry)? □ Yes □ No
6. Do you give ECCHC permission to share the Patient's electronic medical record among their healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE)? □ Yes □ No

Please initial:

Consent for Treatment

_____ I authorize Eau Claire Cooperative Health Center, Inc. (ECCHC) to provide medical, surgical, dental and hospital treatment including, but not limited to, X-ray, examinations, injections, laboratory work to include routine, opt-out HIV testing as may be advisable or necessary by the attending professional staff.

General Release /Assignment of Benefits

_____ I guarantee payments of all charges incurred for the amount of this patient including transportations and care at any hospital or other facility by a physician and assign any benefits for that patient to ECCHC. I hereby authorize ECCHC to furnish from its records any information requested by insurance of liable third parties in connection with the above assignments.

Medical Release/Assignment

_____ I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act (Medicare) is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers, or any additional third party responsible for payments of benefits any information needed for this or any Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges for clinic and physician visits by physicians for whom ECCHC is authorized to bill. I understand that I am responsible for any insurance deductible and coinsurance.

Signature: _____ Date: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____