**A. Patient Information:**

Patient Name: _____ Date of Birth: _____ Age: _____ Gender: ____

Mailing Address: _____ City: _____ State: ___ Zip: _____

Home Phone:_____ Cell Phone:_____

Patient Social Sec. #:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Employer: _____ Occupation:_____

Address:_____ Phone: _____

**B. Insurance Information: <u>Please provide a copy of your insurance card</u>**

Name of **<u>Primary</u>** Insurance Company: _____

Person responsible for billing payments (Guarantor): _____

Guarantor Date of Birth: _____Guarantor Social Sec. #: _____

Guarantor Mailing Address: _____City: _____State: _____ Zip: _____

Guarantor Home Phone:_____ Cell Phone:_____

Name of **<u>Secondary</u>** Insurance Company: _____

Person responsible for billing payments (Guarantor): _____

Guarantor Date of Birth: _____Guarantor Social Sec. #: _____

Guarantor Mailing Address: _____City: _____State: _____ Zip: _____

Guarantor Home Phone:_____ Cell Phone:_____

**C. Financial:**

To ensure that payment of fees is not a barrier to care, Mainline Health Systems, Inc. may consider a waiver of fees. A sliding fee application must be completed to request a Waiver of Fees.

- ☐ **YES**, I request a waiver of fees.
- ☐ **NO**, I do not request a waiver of fees.

To determine eligibility for patient assistance programs and for federal reporting necessary to continue funding for this facility, please complete: Number of Household Dependents: _____ Gross Household Income: $_____

**D. Emergency Contact:**

Emergency Contact:_____Relationship:_____Phone:_____

Emergency Contact:_____Relationship:_____Phone:_____

Emergency Contact:_____Relationship:_____Phone:_____

**E. Release of Information:**
The following individuals **MAY BE TOLD** about my personal health information, illness, and/or treatment**. If there is no one that you wish to list, then please mark N/A or not applicable.** A minor's (under age 18) health information may be discussed with their legal guardian without a signed authorization.

☐ By checking this box, I authorize the release of information to the noted individuals listed in Section D: Emergency Contact.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

**F. Reporting Demographics**
Please select the patients **Race:**

☐White/Caucasian ☐African American/Black ☐Hispanic/White ☐Asian
☐Native Hawaiian ☐American Indian ☐Other Pacific Islander ☐Refuse to Report

Please select the patients **Ethnicity:**

☐Hispanic/Latino ☐Non-Hispanic/Latino

During the past 24 months, have you or a dependent worked on a farm seasonally or year-round?

☐YES ☐NO

During the past 24 months, have you or a dependent moved or established a temporary residence for farm work?

☐YES ☐NO

Please select any options that apply to the patient:

☐Veteran ☐Homeless ☐Live in Public Housing ☐Migrant ☐None

**G. Patient Portal**
Mainline Health Systems, Inc. provides a secure patient portal via the internet that is designed to enhance patient, provider, and care team communications to improve patient care and satisfaction.

**It is the responsibility of the patient to keep unauthorized individuals from learning their passwords and allowing access to their email information or portal account. It is also the responsibility of the patient and/or guardian to notify Mainline Health Systems, Inc. of any email address changes. Mainline Health Systems, Inc. offers patient portal access to patients 18 years and older or to the legal guardian of a minor child. Mainline Health Systems, Inc. provides the patient portal as a courtesy to our valued patients. If abuse or negligent usage is suspected, Mainline Health Systems, Inc. reserves the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal.**

[ ] **I do wish to participate** in the patient portal and therefore acknowledge and have read and fully understand the above agreement and certify that I am 18 years or older or that I am the legal guardian of the minor patient.
**EMAIL: _____**

[ ] **I do NOT wish to participate** in the patient portal.

**H. Informed Consent**

Mainline Health Systems, Inc. is dedicated to providing primary care, dental and mental health services to all our patients. Because physical and emotional problems often go together, we at Mainline Health Systems, Inc. believe the best care is given when health care providers work together. Mainline Health Systems, Inc. patients may be referred to providers from other health care specialties within the MHSI team; members of the treatment team will share clinical information with each other as it is clinically necessary and relates to your treatment.

I hereby voluntarily consent to outpatient care encompassing routine diagnostic procedures, examination, integrated medical care, and dental treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), taking of X-ray, heart tracing, administration of medications prescribed by the provider, and/or behavioral health services. (a) I further consent to the performance of those diagnostic procedures, examinations and rendering of medical, dental, and/or behavioral health treatment by the medical, dental, and behavioral health staff, including nurses, assistants, hygienists, behaviorists and/or other staff as is necessary per provider judgment. (b) I understand, that if I am 18 years or older, I may consent for all health services; otherwise, my parent or legal guardian will need to consent for services. (c) I understand some services at Mainline Health Systems may involve the use of telemedicine equipment and interaction with providers who are not physically onsite for consultation. These sessions are transmitted via secure, dedicated high speed lines and are not videotaped or saved in any way. I understand that the information gathered is strictly used for treatment purpose at Mainline Health Systems and will be maintained in Mainline Health Systems records only.

**Release of Information**: (a) I authorize the clinic to release medical, dental, and behavioral health information to the third-party insurance carriers for the purposes of filing insurance claims related to my (his/her) care and understand that I may be billed for services rendered. (b) I further authorize the release of all health information about treatment here to my (his/her) doctor or any designated by me. (c) I further authorize the ability to view prescriptive history from external sources. (d) I further authorize the release of health information to federal and state governing entities for the purposes of required reporting. (e) I further understand that Mainline Health Systems Inc. is part of an Accountable Care Organization (ACO) in which Medicare beneficiaries' health information may be shared with their health care providers for care coordination. I further understand that I may opt out by calling Medicare.

I understand that this consent form will be valid and remain in effect as long as I (he/she) attend the clinic.
This form has been fully explained to me and I understand its contents.

_____ _____

**Signature of patient or person authorized to consent for patient** **Date**

_____ _____

**Printed name of patient or person authorized to consent** **Relationship if not the patient**

**If the patient is unable to consent, complete the following:**

Reason patient is unable to consent (if applicable): _____

**OFFICE USE ONLY:*
*Employee:* _____
*Date:* _____