TOVA COMMUNITY HEALTH

RESEARCH . CARE . OUTREACH

CLIENT INTAKE FORM

☐ Male ☐ Female

Full Name: ______________________ DOB: ______________

Address: ______________________________________

City: ______________ State: ______________ Zip: __________

Home Phone #: __________ Cell Phone #: __________ Email: __________

Emergency Contact: __________ Relationship: __________ Phone #: __________

Emergency Contact: __________ Relationship: __________ Phone #: __________

Health Insurance: ______________________________________

Policy Holder ID: ______________________ Group Number: ______________

Dental Insurance: ______________________________________

Policy Holder ID: ______________________ Group Number: ______________

Referred by: ______________________________________

Primary Care Provider: ______________________ Phone #: ______________

Medical Conditions List:

☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________

Medication List:

☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________

Pharmacy: ______________________ Phone #: ______________

Health and Wellness Goals: ______________________________________

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Client Signature: ______________________ Date: ______________

MEDICAL AUTHORIZATION FOR TREATMENT AND FINANCIAL DISCLOSURE

I hereby authorize examination, diagnosis and general treatment (including but not limited to use of x-ray and other non-invasive procedures, such as diagnostic tests) to be performed by the medical staff of the medical center. If necessary, I also give my permission for the allied health professionals (social services, nutritionists, nurses, health educators, counselors, etc.) to review my medical record for the purpose of evaluating my overall health needs. I realize that if a medical procedure is required, I will be given additional information.

I hereby authorize the medical center to furnish information from my medical record to any health care provider, which my physician deems necessary to provide for the continuity of my medical care except as follows: (Please list any exceptions or write none)

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I also authorize this medical center to furnish information from the medical record to any insurer, compensation carrier, health facility or social services agency that may be providing financial assistance for my care.

I assign and authorize payment to be made directly to this medical center of all insurance benefits and agree to pay, in a timely manner, any unpaid balance that is my responsibility.

____ _________________________

Patient/Parent/Guardian Signature **Date**

INSURANCE INFORMATION

I request that payment of authorized Medicare benefits be made to the medical center for the services rendered. I authorize the release of needed data to the Centers for Medicare and Medicaid Services and its agents to determine if benefits are payable for these services.

I have read the above and understand and accept these terms. If I should refuse treatment or leave the facility without written consent of the physician, I hereby release the physician and the medical center of all responsibility for my action. I further authorize the medical center personnel to take cultures and use precautions deemed necessary for infectious cases. I am aware of the above contents, but understand that except to the extent that action has been taken based on my authorization, I may withdraw my authorization at any time by written notification to the involved parties.

____ ________________________

Patient/Parent/Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received, read and understand your *Notice of Privacy Practices*. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

____ _______________________

Patient/Parent/Guardian Signature **Date**