Health Care Coalition of Lafayette County
DBA Health Care Collaborative of Rural Missouri
825 South Business Hwy 13, Lexington, MO. 64067 660-259-2440
DBA Live Well Community Health Centers
324 S. Hudson St. P.O. Box 512 Buckner, MO 64016 816-249-1521
1413 N. Jefferson St., Carrollton, MO 64633 660-329-9005
206 N. Bismark, Concordia, MO 64020 660-463-0234
608 Missouri St., Waverly, MO 64096 660-493-2262

Today's Date: ______/______/______

Patient Information

Please Print

Patient Last Name	First Name	Middle Initial	Preferred Name	Gender: ☐ M ☐ F ☐ FTM ☐ MTF ☐ Choose not to disclose ☐ Other
Mailing Address	City	State	Zip	Sexual Orientation: ☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Don't know ☐ Something else ___________ ☐ Choose not to disclose
Home Phone #	Cell Phone #	Preferred Contact Method *(check all that apply)* ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email ☐ Other		
Email Address: *(print below or check the option that applies)* ☐ Do Not Have ☐ Other ☐ Choose Not to Disclose			Date of Birth	Social Security Number
Employer Name and Address				Work Phone #
Emergency Contact Name	Emergency Phone #		Relationship to Patient	
Primary Care Physician Name and Phone #		Pharmacy Name and Phone #		

MARITAL STATUS:
☐ Single ☐ Married ☐ Widow
☐ Partner ☐ Divorced ☐ Legally Separated
☐ Unknown ☐ Decline to Specify

LANGUAGE:
☐ English
☐ Spanish
☐ Other _________

RACE:
☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black/African American
☐ White ☐ Hawaiian Native ☐ Pacific Islander ☐ More than one race
☐ Decline to Specify ☐ Other ________________

ETHNICITY:
☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Decline

EMPLOYMENT STATUS:
☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ On Active Military Duty
☐ Unemployed ☐ Retired ☐ Disabled ☐ Full-Time Student ☐ Part-Time Student

VETERAN:
☐ Yes
☐ No

HOUSING STATUS:
☐ Own/Rent ☐ No Permanent Housing *(homeless)*
** If No Permanent Housing, where are you currently staying?
☐ Street ☐ Doubling up ☐ Transitional ☐ Shelter ☐ Other

TRANSPORTATION STATUS:
Do you need help with transportation?
☐ Yes ☐ No

HAVE YOU BEEN TO THE ER OR ADMITTED TO A HOSPITAL SINCE YOUR LAST VISIT?
☐ Yes ☐ No
** If Yes, were you referred to us from the ER visit?
☐ Yes ☐ No

DO YOU HAVE LIMITED ENGLISH PROFICIENCY?
☐ Yes ☐ No

SEASONAL WORKER:
☐ Yes ☐ No

MIGRANT WORKER:
☐ Yes ☐ No

WOULD YOU LIKE TO BE CONTACTED REGARDING MEDICAL INSURANCE?
☐ Yes ☐ No

DO YOU HAVE A CURRENT ADVANCED DIRECTIVE?
☐ Yes ☐ No

CONSENT TO EXCHANGE RECORDS WITH YOUR OTHER HEALTHCARE PROVIDERS FOR CONTINUITY OF CARE:
☐ Send & Receive ☐ Send Only ☐ Receive Only ☐ Choose to Opt Out

WHAT IS YOUR ANNUAL HOUSEHOLD INCOME?
____

HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD?
____

The above information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against users of the Live Well Community Health Centers (LWCHC – all locations). You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will be released except in collective form.

March 1, 2019

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Responsible Party Information
(if different than patient)

Last Name	First Name	Middle Initial	Relationship to Patient

Mailing Address	City	State	Zip

Home Phone #	Cell Phone #	Date of Birth	Social Security Number

Employer Name	Employer Address	Work Phone #

Primary Medical Insurance

Name of Insurance Company	Policy ID or Member #	Group #	Effective Date

Insurance Claims Address *(Street, City, State, Zip)*	Insurance Phone #

Primary Insured's Name	Primary Insured's Social Security #	Primary Insured's Date of Birth	Relationship to Patient

Primary Dental Insurance

Name of Insurance Company	Policy ID or Member #	Group #	Effective Date

Insurance Claims Address *(Street, City, State, Zip)*	Insurance Phone #

Primary Insured's Name	Primary Insured's Social Security #	Primary Insured's Date of Birth	Relationship to Patient

Secondary Insurance
☐ Medical ☐ Dental

Name of Insurance Company	Policy ID or Member #	Group #	Effective Date

Insurance Claims Address *(Street, City, State, Zip)*	Insurance Phone #

Primary Insured's Name	Primary Insured's Social Security #	Primary Insured's Date of Birth	Relationship to Patient

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THE FOLLOWING AUTHORIZATIONS ARE TO BE COMPLETED AND INITIALED BY A PARENT, LEGAL GUARDIAN OR PERSON REPRESENTING LEGAL CUSTODY TO THE CHILD, PRIOR TO APPOINTMENT WITH OUR PROVIDERS.

ASSIGNMENT OF INSURANCE:
I hereby authorize payment directly to HCC/Live Well Community Health Centers for health care and/or surgical benefits for any services furnished to me or my dependents. I hereby authorize HCC/LWCHC to release any information acquired in the course of my examination or treatment necessary to establish an insurance claim payment. I understand that occasionally my insurance company will deny payment for services that my physician and/or I feel necessary for my good health. Please note that self-pay/sliding scale patients may incur additional charges outside of self-pay office visit fees. I agree to pay for such services in a prompt and timely manner. I hereby authorize HCC/LWCHC providers to prescribe treatment, administer medications, and perform such procedures and tests that may be deemed advisable or necessary in the diagnosis of me or my dependents. ______ **Initials**

RELEASE OF MEDICAL INFORMATION:
I authorize HCC/LWCHC to release information to the following listed below. _______ **Initials**

- ☐ Spouse: ______________________________
- ☐ Children (list names): ______________________________
- ☐ Other: ______________________________

HIPAA NOTICE OF PRIVACY PRACTICES:
I acknowledge that HCC/LWCHC has made available to me the HIPAA notice of privacy practices. _______ **Initials**

AUTHORIZATION TO PROVIDE MEDICAL & HEALTH CARE SERVICES:
I hereby authorize HCC/LWCHC to provide medical examination services, immunological services, and routine medical/health services as considered normal and necessary; to secure and consent to medical, surgical, dental, and psychiatric care that is deemed necessary by a licensed physician, nurse, or mental health provider. _______ **Initials**

APPOINTMENT POLICY:
HCC/LWCHC requires at least 24 hours notice from patients who need to cancel or reschedule an appointment. A patient is considered a No Show, if they are 15 minutes late for their scheduled appointment. It is at the discretion of the Clinic Manager or the Provider whether the patient will be rescheduled or if they can be worked into the schedule.

As a patient of the clinic, you and your family agree to:

1. Arrive early or on time to all scheduled appointments
2. Keep the clinic informed of changes to your contact information.
3. Agree that if you No Show for 3 visits within 6 months that you will be placed on a restricted status of, walk-in or same-day appointments only.
4. If you do not show up for an appointment, you will have a No Show appointment. If you do not give at least 24 hours' notice to cancel or reschedule an appointment or you are asked to reschedule due to late arrival, you will have a broken appointment.
5. Due to the high demand for late afternoon appointments, if a member of your family has a Broken or No Show appointment during these times, you may no longer be able to schedule after-school appointments for your family.

IF I AM UNABLE TO BRING MY CHILD(REN) TO AN APPOINTMENT, I GIVE PERMISSION FOR ______________________ TO BRING THEM.

PATIENT SIGNATURE: ______________________________ **DATE:** ______________

RESPONSIBLE PARTY SIGNATURE: ______________________________ **DATE:** ______________

RESPONSIBLE PARTY NAME (*please print*): ______________________________

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Slide Fee Scale Eligibility Application

Are you interested in applying for the Slide Fee Scale option?

☐ YES ☐ NO

**** Documentation must be provided by the patient or guarantor to determine eligibility for the Slide Fee Scale ****

List Family Members within the Household

NAME	FINANCIALLY RESPONSIBLE	DATE OF BIRTH	MONTHLY INCOME (GROSS)
Self	✓ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

**** ANYONE THAT IS CONTRIBUTING AND/OR DEPENDENT UPON THE HOUSEHOLD INCOME SHOULD BE LISTED ABOVE ****

ACCEPTABLE INCOME DOCUMENTATION

- Current Federal Income Tax Return
- Form W-2 or Form-1099
- Paystubs for the last 30 days
- Retirement/Pension Distributions
- Social Security Benefit Letter
- Disability Benefit Letter
- Forms from State Funded Agencies
- Unemployment Compensation
- Official Documents from Courts (Alimony, Child Support, etc.)
- Investment Gains Statement
- Any other Income not Listed

DECLARATION OF NO INCOME

I certify that I am currently unemployed and do not receive any income as of this date. However, I have been receiving support from the following resources which began ________________.

☐ Relatives/Friends ☐ Energy Assistance ☐ Section 8 Housing ☐ TDPA ☐ Food Stamps ☐ TANF

I do hereby attest that this information is true, accurate and complete to the best of my knowledge as well as the below items.

- I have submitted or will provide proof of ALL household income in order for this application to be processed for financial screening.
- I understand completion of this form does not guarantee a discount.
- If I do not qualify for a discount, I agree to pay in full or set up a payment plan.
- If my financial status changes, I agree to provide LWCHC with current documentation of my financial status at my next visit. I also agree to be re-evaluated annually by providing updated income verification.
- I understand that if I qualify, I must pay a minimum of $35 per appointment for a medical and behavioral health appointment or a minimum of $70 for a dental appointment.

APPLICANT'S SIGNATURE: ______________________________ **DATE:** ______________