PENDLETON COMMUNITY CARE, INC.

Pendleton Community Care
314 Pine Street
PO Box 100
Franklin, WV 26807
304-358-2355

North Fork Primary Care
Rt. 33 & Rt. 28
PO Box 101
Riverton, WV 26814
304-567-2101

Harman Health Center
1 Mott Street
PO Drawer 14
Harman, WV 26270
304-227-4134

DATE:_____ CHART # _____

PATIENT INFORMATION

LAST NAME:_____FIRST_____MIDDLE INITIAL_____

ADDRESS:_____

CITY_____ STATE/ZIP _____

HOME PHONE: ( ) _____ WORK PHONE ( ) _____

CELL PHONE: ( )_____ SOCIAL SECURITY # _____

EMAIL: _____

ARE YOU A(N): VETERAN: YES NO MIGRATE AGRICULTURAL WORKER: YES NO

DATE OF BIRTH: _____ **SEX**: M F **MARITAL STATUS**: SINGLE MARRIED DIVORCED SEPERATED WIDOWED OTHER

SEXUAL ORIENTATION: Lesbian/Gay Straight Bisexual Something else

GENDER IDENTITY: Male Female Transgender Male Transgender Female Other

RACIAL GROUP YOU MOST IDENTIFY WITH: Asian____ Black/African American ____ Caucasian_____ Subcontinent Asian American ____ Other____ Asian Pacific ____ Native American ____ American Indian or Alaskan Native____ Native Hawaiian ____ More than One Race____ Pacific Islander____ Hispanic____ Black (Non-Hispanic)____ White (Non-Hispanic)____

ETHNICITY: Latino/Hispanic____ Other_____ **PRIMARY LANGUAGE**:_____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ PHONE NUMBER: ( )_____

SPOUSE'S EMPLOYER: ___

EMPLOYER ADDRESS: _____ PHONE NUMBER: ( )_____

EMERGENCY CONTACT INFORMATION

NAME OF EMERGENCY CONTACT:_____ RELATIONSHIP:_____

PHONE NUMBER: ( )_____ PHONE NUMBER ( )_____

NEXT OF KIN INFORMATION

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: (_____) _____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

POLICY #_____ GROUP #_____

POLICY HOLDER NAME: _____ DATE OF BIRTH:_____

SECONDARY INSURANCE COMPANY:_____

POLICY#_____ GROUP #_____

POLICY HOLDER NAME: _____ DATE OF BIRTH:_____

HOUSEHOLD INFORMATION (OPTIONAL)

LIST THE MEMBERS IN YOUR FAMILY THAT ARE IN THE HOUSEHOLD.

NAME	AGE	DATE OF BIRTH
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRIMARY CARE PROVIDER (PCP)

IS PENDLETON COMMUNITY CARE, INC. YOUR PRIMARY CARE PROVIDER? YES _____ NO_____

IF YES, WHICH PROVIDER: _____

Authorization and Consent for Integrated Primary Care and Behavioral Health Services Providers to Evaluate, Treat and Share Confidential Information

Patient Consent and Authorization

Authorization and Consent to Evaluation and Treatment: I hereby consent, authorize and give permission to the credentialed health care providers of Pendleton Community Care, Inc. ("PCC") to evaluate and treat the condition(s) for which I (or my child or my dependent, if this consent and authorization is executed on behalf of a unemancipated minor or other dependent for which the undersigned is authorized to act, if so indicated below) have sought evaluation and/or treatment by PCC.

Authorization and Consent to Share Information: I also hereby consent, authorize and give permission to the credentialed health care providers of Pendleton Community Care, Inc. ("PCC") and the clinical and administrative support staff thereof to use and share protected health information as defined under the Health Insurance Portability and Accountability Act (HIPAA) or other applicable laws and statutes, including information about my conditions, diagnoses and/or treatments, and also including such information related to substance abuse, mental health, or medical history. This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, other sexually transmitted diseases, family planning services or other services for which use of protected health information is limited, conditioned or restricted by law. Once my protected health information is shared and released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.

I understand the purpose of sharing information is to help me receive better care. I understand and agree that my protected health information may be used or disclosed for treatment, payment and health care operations and as otherwise permitted by law. This includes using, sharing and disclosing such protected health information with other health care providers and organizations that may be providing care for me that are not part of the PCC organization. I understand that I have the right to review PCC's Notice of Privacy Practices before signing this authorization and consent. I also understand that I may request restrictions on the use and disclosure of my protected health information and that such restriction is binding only if and to the extent agreed by PCC. I understand that PCC does not have to agree to the restriction.

I understand that I can choose to cancel and rescind (in writing) this authorization and consent at any time (but such rescission will not be effective for any services or treatment rendered prior to receipt of such notice of rescission).

Name: _____ (Please print)

Signature: _____

Date: _____/_____/_____

This form is effective upon execution until rescinded or revoked as provided herein or upon termination of the patient relationship with PCC.

ASSIGNMENT OF BENEFITS

I hereby authorize Pendleton Community Care, Inc. to provide information to the insurance carriers concerning my primary care, illness and treatments and I hereby assign to Pendleton Community Care, Inc. all payments for medical services rendered to my dependents or myself. I understand that I am financially responsible for all charges whether or not covered by insurance. I authorize the use of my signature on all insurance admissions.

X_____ X_____

(PATIENT NAME – PRINTED) (PATIENT SIGNATURE)

_____

SIGNATURE OF PARENT OR GUARDIAN (IF MINOR)

MEDICARE / MEDICAID

Authorization for Provider's services:

I request that payment of authorized Medicare and or Medicaid benefits be made to either me or on my behalf to Pendleton Community Care, Inc., for any services provided to me by that Provider. I also authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for the related services.

X_____ _____

PATIENT SIGNATURE SIGNATURE OF PARENT OR GUARDIAN (IF MINOR)

_____ _____

HEALTH INSURANCE NUMBER EFFECTIVE DATE

_____

PRIMARY CARE PROVIDER (IF LISTED)

Pendleton Community Care, Inc.

PERMISSION TO DISCUSS PHI

I hereby give my permission to the person(s) listed below to authorize treatment and to receive information about the care of the above named patient:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IF PATIENT IS YOUR DEPENDENT AND/OR UNDER THE AGE OF 18:

Are you (please circle one): Parent Legal Guardian

Name of legal guardian(s) or parents: _____

**If you are the legal guardian, guardian or custody papers showing custody of child is required

MEDICAL POWER OF ATTORNEY

Name of Medical Power of Attorney: _____

**Please provide a copy of the notarized legal documents for the medical power of attorney.

I certify that all information provided as part of this form is true and correct to the best of my knowledge.

_____ Date: _____/_____/_____

Patient Name – Printed

_____

Patient Signature

_____

Signature of parent/legal guardian/medical POA

Pendleton Community Care, Inc.

Pendleton Community Care	North Fork Primary Care	Harman Health Center
314 Pine Street	16921 Mountaineer Drive	1 Mott Street
Franklin, WV 26807	Riverton, WV 26814	Harman, WV 26270

Consent to Obtain Medication History

By signing below, I give permission for **Pendleton Community Care, Inc.** to access my medication history electronically. This consent will enable **Pendleton Community Care, Inc.** to:

- Download a historic list of all medications prescribed for you by a provider.

_____ _____

Patient Name (Printed) Date of Birth

_____ _____

Patient Signature Date

Pendleton Community Care
North Fork Primary Care
Harman Health Center

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Pendleton Community Care, Inc. Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of my bills or in the performance of Pendleton Community Care, Inc.'s health care operations and for other purposes that are permitted or required by law. It also describes my rights to access and control my protected health information. The Notice of Privacy Practices is also posted in the waiting area of Pendleton Community Care, North Fork Primary Care, and Harman Health Center and on the website (www.pcc-nfc.org).

I understand that Pendleton Community Care, Inc. reserves the right to change my privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practice by calling Pendleton Community Care, Inc. and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment or accessing the website (www.pcc-nfc.org).

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____/_____/_____
Date

_____
Description of Personal Representative's Authority