Well Care
Community Health

203 EAST MAIN STREET
RICHMOND, IN 47374
PHONE # 765-973-9294
FAX # 765-973-9233

Welcome to Well Care Community Health, Inc.

Each patient of Well Care Community Health will be asked to complete a Sliding Fee Schedule application on an annual basis. The following information is requested to show proof of income:

1. Proof of household income. Examples: pay stubs-the 2 most current, child support, Social Security/Disability/SSI, Pension, TANF
   (Discounted fees are available to patients who qualify based on household size and income).
2. Current picture ID, such as driver's license.
3. List of current prescription medication(s). You can write these on the Patient History sheet you were given.
4. Copy of current insurance card

Please have all the above information when you return these forms to the clinic to simplify the appointment process.

Information about the Clinic

Hours	Dental	Evening	Walk-In
Monday-Friday 08:00 AM-05:00 PM	Monday-Friday 08:00 AM-12:00 PM 01:00 PM-05:00 PM BY APPOINMENT ONLY	By Appointment Every second Tuesday, Once a Month	Monday-Friday 08:00 AM-04:00 PM MEDICAL ONLY
Labs 08:00 AM-11:00AM 01:00PM-03:00 PM			

***We ask that you be on time for your appointment. If you are unable to keep your appointment, please call our office to reschedule or cancel within 24 hours of your appointment.**

To contact a health care worker by phone during business hours: Tel (765) 973-9294
TTY Users call: 711 or (800) 743-3333
***Telephone switchboard remains open for calls during lunch**

- Medical Appointment – **Press 1**
- Concerns regarding a recent appointment, test result, or medication – **Press 2**
- Immunizations – **Press 3**
- Medication Refill – **Press 4**
- Dental Appointment – **Press 5**
- To speak to an operator – **Press 0**

After Hours- If you have a medical or dental problem or a question after business hours or during the weekend and you feel it cannot wait until our next business day, please call our on-call system at (765) 914-1859. Or you may call our main number (765) 973-9294 and push 9 to be transferred. A healthcare professional will call you back shortly.

Medication Refill- Call 973-9294 and push option 4 for medicine refills. Leave your name, phone number, medication name, and dosage. Also, leave the name of a pharmacy where the prescription can be called if you do not get the medicine at the clinic. Due to the large volume of calls, it may take 48 hours before the medicine is ready for pickup. Your call is very important to us.

Calling for a Nurse – Please call (765) 973-9294 and push option 2 to speak to a Nurse. Leave a voicemail message with your name, phone number, and a brief message and the nurse will return your call.

Appt. Date: _____

Notes:

WELL CARE COMMUNITY HEALTH
203 EAST MAIN STREET
RICHMOND, IN 47374

SLIDING FEE ELIGIBILITY FORM
and Annual Update

Today's Date: _____

Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
EMR #:

It is necessary for us to ask personal questions to give you a discount on our medical expenses. This information will be kept on file in our Health Center and held in strict confidence You must verify your income at least annually. Your yearly income can be verify by one of the following: tax return, copy of your two (2) current pay stubs (within the past 3 months), disability check stub, SSI check stub, current unemployment check stub/statement, or child support check stub. Your annual income will be used to calculate the level of your payment.

Number of people living in your home? ☐

What is your marital status? ☐Married ☐Widow(er) ☐Single ☐Divorced ☐Separated

Amount of Gross Household Income:
(before taxes and other deductions)

You	Your Spouse	Your Children	Other Person	Total Family Income

Place of Employment:

You	Your Spouse	Your Children	Other Person

Veteran: ☐ ☐ ☐ ☐

Do you receive any income from any of the following sources, and if so, how much?

Source	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					

Do you have any type of insurance that will cover all or a portion of your medical expense? ☐ Yes, list below ☐ No

Give Names, DOB, and relationship of all individuals living in the household:

Name	Date of Birth (DOB)	Relationship to patient

I declare the above information is true and have given the Well Care Community Health, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Signature: Print:	Date:	***Clinic Purpose Only:*** Income Code:

Well Care
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Name:_____ Maiden Name:_____
First Middle Initial Last or other name used

PATIENT INFORMATION

Race: ☐ American Indian/Alaska Native ☐ Black/African American ☐ Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than (1)
☐ Unknown/Refused ☐ Caucasian

Veteran ☐ Yes ☐ No

Ethnicity: ☐ Non Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown/Refused

Language: ☐ English ☐ Spanish ☐ French
☐ Mandarin ☐ Japanese ☐ Other _____

SS# _____ Birth Date_____ Marital Status: S M D W Sex: M F

Address_____
Street City State Zip

List your contact number and √ your preferred contact method below:

Home ☐ _____ Cell ☐ _____ Portal ☐_____

Email Address _____

SLIDING Fee Available upon request: ☐ Annual Income:_____ Size of Household: _____

Employer Name _____ Status: F/T P/T Retired None

Employer Address _____
Street City State Zip

Student Status if applicable: Full-time Part-time Name of College/Univ/School_____

Primary Care Physician _____ Referred by _____

Birth Mother's Full Name _____
First Middle Initial Last Maiden

INFORMATION FOR MINORS

Note: If the patient is a minor, please complete this section regarding financial responsibility

Guarantor Name _____

Address (if different from patient's) _____
Street City State Zip

EMERGENCY CONTACT INFO

Name _____ Relationship _____ Phone_____

Address_____
Street City State Zip

Name _____ Relationship _____ Phone_____

Address_____
Street City State Zip

INSURANCE INFORMATION

PRIMARY CO_____ Policy/ID#_____Group_____

Insured Party: Self Spouse Parent Insured Name (if not the patient)_____

Birth date _____ SS#_____ Employer_____ Emp Tel_____

SECOND CO_____ Policy/ID#_____Group_____

Insured Party: Self Spouse Parent Insured Name (if not the patient)_____

Birth date _____ SS#_____ Employer_____ Emp Tel_____

THIRD CO_____ Policy/ID#_____Group_____

Insured Party: Self Spouse Parent Insured Name (if not the patient)_____

Birth date _____ SS#_____ Employer_____ Emp Tel_____

I give my consent for Well Care Community Health, Inc. to use and disclose my protected health information (PHI) for treatement, payment, and continuity of care. The insurance information I have provided on this form is accurate and complete. If I have not listed insurance info., then I understand I am responsible for payment.

Patient or responsible party signature:_____ **Date:**_____

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Please answer the following question regarding your health. This information will be used by our medical, behavioral health, and dental care teams to provide you with the best possible care.

Patient Name: _____ Date of Birth: _____ Date Completed: _____

Are you under a physician's care now? ☐Yes ☐No If yes, name: _____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, when: _____

Have you ever had a serious head/neck injury? ☐Yes ☐No If yes, when: _____

Have you ever taken Fosamax, Boniva, Actenol, or any other medications containing bisphosphonates? ☐Yes ☐No If yes, when: _____

Do you use tobacco or past tobacco user? ☐Yes ☐No If yes, when: _____

Do you use any controlled substances: ☐Yes ☐ No If yes, when: _____

Women: **Pregnant** ☐Yes ☐ No **Trying to get pregnant?** ☐Yes ☐ No **Nursing** ☐Yes ☐ No **Taking birth control** ☐Yes ☐ No

Are you allergic to any of the following:

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs

☐Silver ☐Red Dye ☐Iodine ☐None ☐Local Anesthetics ☐Other _____

Do you have, or have you had any of the following?

☐AIDS/HIV Positive	☐Chest Pains	☐Stomach Disease	☐Epilepsy or Seizures	☐Radiation Treatments
☐ Alzheimer's Disease	☐Cold Sores/Fever Blisters	☐ Intestinal Disease	☐Hives or Rash	☐Hepatitis B or C
☐ Anaphylaxis	☐Heart Pacemaker	☐Stroke	☐Hypoglycemia	☐Anemia
☐Herpes	☐Psychiatric Care	☐Cancer	☐Irregular Heartbeat	☐Emphysema
☐ High Blood Pressure	☐Cortisone Medicine	☐Chemotherapy	☐Spina Bifida	☐Scarlet Fever
☐ Artificial Heart Valve	☐Diabetes	☐Heart Attack/Failure	☐Breathing Problems	☐Shingles
☐ Artificial Joint	☐Drug Addiction	☐Heart Murmur	☐Bruise Easily	☐Sickle Cell Disease
☐Asthma	☐Rheumatic Fever	☐Parathyroid Disease	☐Glaucoma	☐Sinus Trouble
☐Blood Disease	☐Arthritis	☐Sexually Transmitted Disease	☐Mitral Valve Prolapse	☐Blood Transfusion
☐ Leukemia	☐Excessive Bleeding	☐Hemophilia	☐Osteoporosis	☐Frequent Headaches
☐Liver Disease	☐Excessive Thirst	☐Hepatitis A	☐Pain in Jaw Joints	☐Low Blood Pressure
☐Swelling of Limbs	☐Fainting/Dizziness	☐Renal Dialysis	☐Convulsions	☐Lung Disease
☐Thyroid Disease	☐Kidney Problems	☐Angina	☐Yellow Jaundice	☐Tonsillitis
☐Tuberculosis	☐Congenital Heart Disease	☐Heart Trouble/Disease	☐Recent Weight Loss	☐Syphilis

Have you ever had a serious illness not listed above? ☐Yes ☐No, If yes, explain: _____

Medications, Comments, and Important Additional Information:

_____

_____

_____

_____

To the best of my knowledge, the above information is complete and correct, I understand that it is my responsibility to inform the staff if I, or my minor child, ever have a change in medical or dental health. I give my consent for Well Care Community Health to use and disclose my protected health information (PHI) for treatment, payment, and care options (TPO). I have received a copy of the Notice of Privacy Practices. Well Care Community Health, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items, and any calls about my clinical care, including test results. I have the right to request Well Care Community Health, Inc. restrict how it uses or discloses my PHI, however, the practice is not required to agree to my restrictions.

Signature of Patient, Parent or Guardian: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT AND DESIGNATION OF PERSONAL REPRESENTATIVE

Patient Name: _____ Date of Birth: _____

Acknowledgement:

I hereby acknowledge that I received and/or was offered a copy of this practice's Notice of Privacy Practices:

Signed: _____ Date: _____

Print Name: _____ Phone: _____

If not signed by the patient, please indicate relationship: _____

Designation ☐ **Declined** ☐ **Revised**

I authorize the practice to disclose or provide my protected health information to the following individual(s) who is (are) authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent to authorize the use or disclosure of my protected health information:

_____ _____

(Printed Name of Personal Representative) (Include: Relationship, Date of Birth, and Phone Number)

_____ _____

(Printed Name of Personal Representative) (Include: Relationship, Date of Birth, and Phone Number)

_____ _____

(Printed Name of Personal Representative) (Include: Relationship, Date of Birth, and Phone Number)

Description of information to be disclosed: I authorize the practice to disclose all of my protected health information to my designated personal representative(s).

Expirations or termination of authorization: This authorization will remain in effect until terminated by you or your personal representative(s).

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed to your personal representative will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

_____ _____

Signature Date

Well Care
Community Health

your choice for better care

Medical
Dental
Behavioral

Patient Consent for Care Form

Consent to Care: Account:_____

I, the undersigned, for myself or a minor child/children or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Well Care Community Health on an outpatient/office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by an advanced practice provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

To the Patient:
You have the right to discuss the treatment plan with your health care provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent:

Complete this section if patient is a minor: *(if not, skip to next section)*
I hereby give my consent to treat minor child/children below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Well Care Community Health. Any care deemed medically necessary may be provided with or without my presence:

Child: _____ Date of Birth: _____

Child: _____ Date of Birth: _____

Child: _____ Date of Birth: _____

Consent for Care:
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Patient

This consent to medical treatment will remain in effect from the date signed until revoked in writing.

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Patient Name: _____ **Date:** _____

In order to gain a better understanding of the populations we serve, and comply with federal guidelines, we need for you to complete the questions below and return to the check-in staff.

1 Veteran Status - Please mark one

- ☐ Yes
- ☐ No

RACE and Hispanic, Latino/a, or Spanish Ethnicity

2

	Not Hispanic, Latino/a or Spanish Origin	Yes, Mexican American, Chicano/a	Yes, Puerto Rican	Yes, Cuban	Yes, Another Hispanic, Latino/a, or Spanish Origin	Yes, Hispanic, Latino/a, Spanish Origin, Combined	Chose Not to Disclose Ethnicity
White							
Asian Indian							
Chinese							
Filipino							
Japanese							
Korean							
Vietnamese							
Other Asian							
Native Hawaiian							
Other Pacific Islander							
Guamanian or Chamorro							
Samoan							
Black/African American							
American Indian/Alaska Native							
More than one race							
Prefer to not disclose race							

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Please check the box that best describes the income of your household. This information is requested annually.

Income as a Percent of Poverty Guidelines

Please enter size of household: _____

Name: _____

Date: _____

Family Size	Household Income 0-100%	101%-150%	151%-200%	Over 200%
1	$0 to $15,060.00 ☐	$15,060.01-$22,590.00 ☐	$22,590.01- $30,120.00 ☐	$30,120.01 and up ☐
2	$0 to $20,440.00 ☐	$20,44001- $30,660.00 ☐	$30,660.01- $40,880.00 ☐	$40,880.01 and up ☐
3	$0 to $25,820.00 ☐	$25,820.01- $38,730.00 ☐	$38,730.01- $51,640.00 ☐	$51,640.01 and up ☐
4	$0 to $31,200.00 ☐	$31,200.01- $46,800.00 ☐	$46,800.01- $62,400.00 ☐	$62,400.01 and up ☐
5	$0 to $36,580.00 ☐	$36,580.01- $54,870.00 ☐	$54,870.01- $73,160.00 ☐	$73,160.01 and up ☐
6	$0 to $41,960.00 ☐	$41,960.01- $62,940.00 ☐	$62,940.01- $83,920.00 ☐	$83,920.01 and up ☐
7	$0 to $47,340.00 ☐	$47,340.01- $71,010.00 ☐	$71,010.01- $94,680.00 ☐	$94,680.01 and up ☐
8	$0 to $52,720.00 ☐	$52,720.01- $79,080.00 ☐	$79,080.01- $105,440.00 ☐	$105,440.01 and up ☐

As a Federally Qulified Health Center (FQHC), we are required to collect certain data on our patients. This data is in no way used to determine your eligibility to receive care here, the type of care you can receive or the frequency you can come in for care. ***This is strictly for statistical puposes*** .

☐ **I refuse to disclose my income information to Well Care Community Health, Inc.**

Signature:_____ **Date:** _____

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How did you hear about the clinical services at the Well Care Community Health?

Please choose from the following:

____ Personal preference for family physician

____ Referrals from family/friends/co-workers

____ Newspaper

____ Radio

____ Cable television

____ Billboards

____ Social Media

- Facebook
- Instagram
- Pinterest
- Twitter
- Comcast Media website
- Palladium Item Mobile Device

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