Medical/Behavioral Health
2200 W. Main Street
Richmond, IN 47374
Phone: 765-973-9294

Dental
100 Mattie Harris Rd.
Centerville, IN 47330
Phone 765-855-3435

Welcome to Well Care Community Health

This sheet will provide you with important information about being a patient at Well Care. We are all so glad you have chosen us to be your healthcare provider.

1. Well Care offers a **sliding fee discount** to patients under 200% of poverty. You may be eligible for this discount even if you have insurance. Please ask our front office team for an application if you are interested in applying. If qualified, the savings can be substantial.
2. Well Care is required to ask you the number of household members and household income. Your answers to these questions in NO WAY impact your ability to receive care at Well Care.
3. At your first appointment or when you return the new patient packet, please have with you the following:
   a. A photo ID such as a driver's license
   b. A list of your current medications
   c. Your insurance card
4. Services are available during the following hours:

Medical and Behavioral Health	**Dental Centerville Only**	**Evening Medical Appointments**	**Walk-In Medical Care**	**Walk-In Laboratory**
8:00 am to 5:00 pm Monday-Friday	8:00 am to 5:00 pm Closed from 1 pm-2 pm Monday-Friday	By appointment only	8:00 am to 4:00 pm Monday-Friday	8:00 am-11:00 am 1:00 pm to 3:00 pm

To contact a health care worker by phone during business hours call (765) 973-9294

TTY Users call: 711 or (800) 743-3333

- 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 or holiday and you feel it cannot wait until our next business day, please call our on-call number at (765) 914-1859. You may also call our main number (765) 973-9294 and push 9 to be transferred. A healthcare professional will call you back shortly.

Medication Refill - Call 765-973-9294 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. 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.

Annual Update

Well Care Community Health

PATIENT INFORMATION

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

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

Address _____
Street City State Zip

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

Military: ☐ Yes ☐ No

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

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

List your contact number and check your preferred contact method below:
Home ☐ _____ Cell ☐ _____ Portal (email required) ☐ _____

Annual Household Income: _____ Size of Household: _____ Sliding Fee Application: Y or N

Employer Name _____

Primary Care Physician _____ Referred by _____

INFO 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 _____

Please check all that apply: ☐ Emergency Contact ☐ Caregiver ☐ Next of kin

Address _____
Street City State Zip

Name _____ Relationship _____ Phone _____

Please check all that apply: ☐ Emergency Contact ☐ Caregiver ☐ Next of kin

Address _____
Street City State Zip

INSURANCCE 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 treatment, 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:** _____

Well Care Community Health

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, name_____
Have you ever had a serious head/neck injury?	☐ Yes	☐ No	If yes, name_____
Have you ever taken Fosamax, Boniva, Actenol, or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes, name_____
Do you use tobacco or past tobacco user?	☐ Yes	☐ No	If yes, name_____
Do you use any controlled substances:	☐ Yes	☐ No	If yes, name_____

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	☐ Local Anesthetics	☐ None	☐ 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 continuity of care (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 pertaining to 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:** _____

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

Patient Name: _____ Date of Birth: _____

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

Signature: _____ **Date:** _____

Printed Name: _____ **Phone Number:** _____

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) (Phone Number)

_____ _____
(Printed Name of Personal Representative) (Phone Number)

_____ _____
(Printed Name of Personal Representative) (Phone Number)

Description of information to be disclosed: authorize the practice to disclose all of my protected health information to my designated personal representatives).

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:** _____

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.

Complete this section if patient is a minor: *(if not, skip to signature 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.

Well Care
Community Health