MarillacHealth
Committed to a healthier you.

THE PIC PLACE

Complete and bring with you to your new patient appointment or you may complete in the office. Please come 20 minutes early for your new patient appointment.

Demographic Information

Date this Form Was Completed:					
Legal First Name:		Legal Last Name:		Middle Initial:	
Preferred Name (if different than above):		Previous Names (i.e., maiden, married):			
Date of Birth:		Social Security Number (not required):			
Sex: Male / Female	Gender Identity:	Male	Female	Transgender	Other: _________
	Preferred Pronouns:	He/Him	She/Her	They/Them	Other: _________
Race:	White/Caucasian	Black/African American	American Indian/Alaska Native		
	Asian	Pacific Islander/Hawaiian	More than one race	Prefer Not to Answer	
Ethnicity:	Hispanic/Latino	Not Hispanic/Latino	Prefer Not to Answer		
Marital Status:	Married	Single	Divorced	Separated	Widowed	Partner
Sexual Orientation:	Straight/heterosexual	Lesbian/gay	Bisexual	Other	
Veteran Status:	Veteran	Spouse of Veteran	Not Applicable		
Household Status:	Not Homeless	At risk of homelessness	Transitional housing		
Living with others	Single-occupancy hotel	Living in shelter	Homeless unknown shelter		
Child at risk of homelessness	Currently, not homeless, was in last 12 months	Street, camp, bridge	Veteran at risk for homelessness		
Employment Status:	Full-time	Part-time	Self-employed	Not employed	Retired
Disabled	Child	Full-time student	Part-time student	On active military duty	
Migrant Worker	Seasonal Worker				
Household Income: ** Note: This does not replace sliding fee Application process*	Family Size ________	Annual Household Income $___________			

Contact Information

Physical Address:	City:	State:	Zip:
Mailing (if different):	City:	State:	Zip:
Cell:	Can we text this number? Yes No Can we leave detailed voicemails with health info? Yes No		
Home:	Can we leave detailed voicemails with health info? Yes No		
Work:	Can we leave detailed voicemails with health info? Yes No		
We will use this email address for the patient portal unless you opt out	Email Address: _________________________	_____ I choose to opt out	
Creates a portal account for another person to access your health information	Email Address: _________________________	Relationship to you: ______________________	

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Emergency Contacts and Next of Kin

By listing these individuals, you are providing us with the permission to contact them in the event we are unable to reach you at the contact numbers you have provided.

	Name	Relationship	Phone Number
Emergency Contact 1			
Emergency Contact 2			
Next of Kin			
Guardian (if applicable)		Legal Guardian	
Home Support Agency / Caregiver (if applicable)		Agency/Caregiver	
Home Facility (if applicable)		Home Facility	

Sharing My Protected Information

_____You can discuss my Health Information with the following people. I understand that it is up to me to update this list if I wish to make changes.	_______You may NOT discuss my Health Information with anyone. I understand that it is up to me to update this list if I wish to make changes.

First Name: Last Name: Relationship: Phone Number:
What can be discussed: All Test Results Prescriptions Appointments Billing

First Name: Last Name: Relationship: Phone Number:
What can be discussed: All Test Results Prescriptions Appointments Billing

All health information, including billing, may be communicated to the above listed individuals except for the following:

- Diagnosis or reference to behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS); human immunodeficiency virus (HIV); sexually transmitted infection (STI); or drug and/or alcohol abuse.

This authorization will automatically expire 1 year from the date signed below unless I request an expiration date less than one (1) year.

I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.

Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule.

My signature is required to validate this authorization. If I do not sign this authorization Marillac Health will still provide treatment and seek payment for services provided. According to State Statures, this care site may change for copies of medical records.

Health Coverage Information

Primary Insurance		Subscriber's Name		Date of Birth	
Subscriber's ID		Group #		Member ID #	
Relationship to Subscriber					
Secondary Insurance		Subscriber's Name		Date of Birth	
Subscriber's ID		Group #		Member ID #	
Relationship to Subscriber					

Current Health Care Providers (Care Team)	Name	Office	Date of Last Visit	I Don't Have Provider
Dentist				
Medical Doctor				
Counselor/Therapist				
Eye Doctor				
Specialist*(type):*				
Specialist*(type):*				
Specialist*(type):*				

	Name	Phone Number	Address (if known)
Preferred Hospital			
Preferred Laboratory			
Preferred Pharmacy *(local)*			
Preferred Pharmacy *(mail in)*			
Medical Equip Provider			

By signing below, I attest that the information I have provided is accurate. I agree to update information as requested by the Clinic or when I have personal changes that change the information provided above.

____ _________________________

Printed Patient Name Date

____ ____

Patient/Legally Authorized Representative Signature If other than patient, Print name and Relationship

2333 N. 6th St. Grand Junction, CO 81501
2139 N. 12th St., Ste. 2 Grand Junction, CO 81501
510 29 ½ Rd. Grand Junction, CO 81504
87 Merchant Drive, Montrose, CO 81401

Phone: 970-200-1600
Fax: 970-200-1611
MarillacHealth.org
Phone: 970-252-8896 Fax:970-240-3095

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Medical/Social Health History Questionnaire

Today's Date _______________

Patient Last Name ____ DOB _________________________

Family History

Relationship	Diabetes	High Blood Pressure	High Cholesterol	Heart Attack	Cancer	Type of Cancer	Stroke	Blood Clots (legs, lungs,	Mental Health Issue	Substance Abuse	Other	Living Status
Mother												__ Alive __ Deceased
Father												__ Alive __ Deceased
Sister												__ Alive __ Deceased
Brother												__ Alive __ Deceased
Daughter												__ Alive __ Deceased
Son												__ Alive __ Deceased
Maternal Grandmother												__ Alive __ Deceased
Maternal Grandfather												__ Alive __ Deceased
Paternal Grandmother												__ Alive __ Deceased
Paternal Grandfather												__ Alive __ Deceased
Other important history, you want us to know about:												

Patient History

E-Cigarettes/Vaping (Circle one) Current Every-Day User Current Some-Day User Never Use

Former User Never assessed User-Current Status Unknown Unknown if Ever Used

E-Cigerette/Vaping Substance (Circle all that apply) Nicotine THC CBD Flavoring Other

Please list "Other" ____

E-Cigarettes/Vaping Devices (Circle all that apply) Disposable Pre-filled or Refillable Cartridge

Refillable Tank Other (Please list) ____

Tobacco Smoking (Circle one) Never Former Every Day Some Days Unknown

Smokeless (Circle one) Never Former Current Unknown

Passive Exposure (Second-hand smoke) (Circle One) Never Past Current

Would you like counselling on tobacco cessation? Yes No

Medical/Social Health History Questionnaire

Alcohol

Do you drink Alcohol? Yes Not Currently Never

Drinks per Week? Glasses of Wine ___ Cans of Beer ___ Shots of Liquor ___ Drinks containing .05 oz of Alcohol ___

Did/do you ever drink excessively? Yes No Do you ever drive after drinking? Yes No

Drug Use (Circle one) Yes, Currently Not Currently Never **How many times per week?** ___________

Types (Circle all that apply) Vaping Marijuana Opioids Heroin Methamphetamine

Amphetamines PCP ecstasy LSD Ketamine Mescaline Psilocybin Cocaine

Crack Nitrous Oxide Solvent Inhalants Barbiturates IV Other

Caffeine Intake

Do you drink/take caffeine? Yes No Number of cups/cans or amount taken per day? ____

Pharmacy Please list the name of your preferred pharmacy ____

Health Concerns/Diagnoses/Health Conditions Please list all current medical and mental health issues.

Issue Onset

____
____
____
____
____

Surgeries Please list all previous surgeries and/or procedures.

Surgery Reason When/Where

____
____
____

Allergies Please list all allergies (medications, food, bee stings, etc.) and how they affect you.

Allergy Reaction

____
____
____

Medical/Social Health History Questionnaire

Medications Please list all current medications that you are taking including over-the-counter medications.

Name	Dose	Frequency	Purpose	Who Prescribed

Accountable Health Communities Model Screening Tool

*Our goal is to connect you to the community resources you need to be healthy. This screener can help connect you to services in your community that may improve your health. Many of these services are low cost or free of charge. By answering these questions we may be able to provide you with connection to services or programs that may help you. You information will be kept confidential. The information that you provide will not impact your Medicare or Medicaid eligibility status. You should answer the questions in your own way. There are no right or wrong answers. Questions labeled with * are required.*

***First Name:__________________ Middle Name: ______________ *Last Name:____________________**

*****Date of Birth:________________________

Information

*Complete the following statement. I am answering this survey about …

□ Myself □ My child □ Other *(please describe your relationship to this person* ________________________

Health Coverage Type

*Health Coverage Type:

□ Medicaid □ Medicare □ Commercial □ Uninsured □Other

*How many times have you received care in an emergency room (ER) over the last 12 months?

If you are in the ER now, please count your current visit. Please do not count urgent care visits.

□ 0 times □ 1 time □ 2 or more times

Living Situation

What is your living situation today?

□ I have a steady place to live

□ I have a place to live today, but I am worried about losing it in the future

□ I do not have a steady place to live *(I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building)*

Think about the place you live. Do you have problems with any of the following?

□ Pests such as bugs, ants, or mice

□ Smoke detectors missing or not working

□ Oven or stove not working

□ Mold

□ Lead paint or pipes

□ Lack of heat

□ Water leaks

□ None of the above

Food

Within the past 12 months, you worried that your food would run out before you got money to buy more.

□ Often true □ Sometimes true □ Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

□ Often true □ Sometimes true □ Never true

Transportation

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?

□ Yes □ No

Utilities

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

□ Yes □ No □ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. (Please circle appropriate answer.)

How often does anyone, including family and friends, physically hurt you?

Never Rarely Sometimes Fairly often Frequently

How often does anyone, including family and friends, insult or talk down to you?

Never Rarely Sometimes Fairly often Frequently

How often does anyone, including family and friends, threaten you with harm?

Never Rarely Sometimes Fairly often Frequently

How often does anyone, including family and friends, scream or curse at you?

Never Rarely Sometimes Fairly often Frequently

Family and Community Support

How often do you feel lonely or isolated from those around you?

□Never □ Rarely □ Sometimes □ Often □ Always

Household Information

How many people do you currently live with? *Please count yourself, your spouse/partner, your children, and any other dependents. If you live alone, put 1.*

_____number of people

What is your annual household income from all sources?

Please include your income as well as the income for everyone you counted above in your household.

- ☐ Less than $10,000
- ☐ $10,000 to less than $15,000
- ☐ $15,000 to less than $20,000
- ☐ $20,000 to less than $25,000
- ☐ $25,000 to less than $35,000
- ☐ $35,000 to less than $50,000
- ☐ $50,000 to less than $75,000
- ☐ $75,000 or more

What is the number of children under the age of 18 in your household? __________

You may be eligible for free, local care coordination services. Care Coordinators can help you navigate local resources such as housing assistance, accessing affordable/free food, transportation to medical appointments, utility payment support and other resources you may not realize are available.

I understand that this information may be shared with a care coordinator and that the care coordinator may contact me to help me access community resources for my identified needs.

Phone number care coordinator should use to contact you: _________________.

If you do not want care coordination at this time, please check here ☐

FOR OFFICE USE ONLY

☐ Client has accepted navigation

☐ Client has declined navigation

Date Screened: ______________________

Date Entered in QHN: ______________________

Questions used with permission from the following authors (listed by number):

1 National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

2 Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.

3 Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146

4 National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

5 Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., . . . Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286

6 Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. Family Medicine, 30(7), 508-512

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Authorization for Treatment

PERMISSION FOR TREATMENT:

I understand that all patients of MarillacHealth may be seen by staff or volunteer physicians, physician's assistants, or nurse practitioners who are licensed in the State of Colorado and are supervised by the Clinic's Medical Director and/or Dental Director. I hereby give permission for evaluation and treatment, for myself or for the minor child named, by these providers. I understand that the Clinic functions as a teaching facility for medical/dental students of all disciplines, and those patients may be seen by these students. I understand that all students are under the direct supervision of the medical/dental staff of the Clinic. I understand that I have the right to request that I not be treated by a student. I understand that this care may include routine clinic procedures, diagnostic testing, intravenous therapy, injections, minor surgery, and no guarantees have been made to me about the services, treatment, or the outcome of this care. I understand that my prescription history may be obtained from any pharmacy I may have used.

USE AND DISCLOSURE OF INFORMATION FOR TREATMENT AND HEALTHCARE OPERATIONS:

I understand that federal regulations permit the Clinic to obtain, use, and disclose my protected health information for treatment, payment and health care operations and as otherwise allowed by law, as explained in the Clinic's Notice of Privacy Practices. I also understand that some or all of my medical records (or copies of my medical records) may be disclosed or provided to other health care providers (such as physicians, nurses, psychologists, or their staff) involved in my current or future treatment. This type of disclosure may be by written correspondence, in person, by fax, by phone, or other means. I understand that my permission is not needed for those uses or disclosures. The Clinic may also release my information in order to process payment claims. While this office will make reasonable efforts, I understand that the confidentiality of my medical records cannot be ensured once they leave this office. I understand that my picture may be taken and or my photo ID may be scanned and used for identity verification. I understand my records may contain identifying information including photographs, examination, treatment, diagnosis and prognosis and amounts charged and paid, as well as sensitive information concerning substance abuse, psychiatric history and treatment, HIV status, any diagnosis / treatment for AIDS or AIDS-related disease, sexual orientation, and/or sexual activities or disease. I understand that this information may be released or disclosed as necessary in accordance with the Clinic's Notice of Privacy Practices unless otherwise protected or provided for by state or federal law. I understand that I may request restrictions on how any of my health information and/or my medical records is to be used, disclosed or shared. (I understand that the Clinic and St. Mary's Hospital participate in a Continuum of Care Agreement whereby billing and clinic information is shared without specific consent from me.) I understand that the Clinic utilizes a collaborative care model for treatment and that mental health records are part of the medical record.

PATIENT FINANCIAL RESPONSIBILITY:

I agree to provide all financial information requested by the Clinic in order to qualify for services. I attest that all of this information is accurate to the best of my knowledge. I understand that if I provide false financial information or fail to update changes in income or insurance status, that I may no longer be eligible for Clinic services. I understand that the Clinic expects payment of incurred expenses at the time of the visit. If I am not able to pay the reduced fee at this time, I will meet with the Clinic's appropriate personnel to make payment arrangements. I understand that there may be additional fees for Immunizations, lab work, procedures, medications or other items. I understand that I may be referred

to a specialist physician for consultation or treatment. I understand that I, as the patient, am financially responsible for payment of all charges for services provided by these specialists. I understand that the Clinic is not financially responsible and will not pay for any services outside the Clinic. I understand that the Clinic provides only routine, outpatient care during regular posted office hours, and that should emergency or life-threatening events occur I will access care at an emergency facility at my own expense. I understand that if I am in a life-threatening condition while at the Clinic, emergency transportation will be called to transport me to an emergency room. I understand that I am financially responsible for the cost of such emergency care and transportation. I realize that failure to keep my appointments, to cancel my appointments or arrive late for an appointment may jeopardize my eligibility for continued care at the Clinic.

ASSIGNMENT OF BENEFITS / MEDICARE AND MEDICAID:

I certify that the information given by me in applying under Title XVIII of the Social Security Act is correct.

I authorize the Clinic to release to the Social Security Administration or its intermediaries or carriers or insurance companies any information needed for this or a related Medicare/Medicaid claim or a private insurance claim. I assign the benefits payable for the physician services to the physician or organization furnishing the services so that the Clinic can directly be paid or authorize such physician or organization to submit a claim to Medicare/Medicaid for payment to me.

I understand this entire consent, financial responsibility and assignment of benefits form will be valid now and in the future until revoked in writing by me and the revocation given to the clinic.

Signature of Patient or Legal Guardian	Today's Date
PRINTED Name of Patient or Legal Guardian	Relationship to Patient
Patient Name	Patient DOB

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Notice of Privacy Practices

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions, contact Privacy Officer at 970-200-1600; or by mail at 2333 N. 6th Street, Grand Junction, CO 81501. To learn more about MarillacHealth, please visit our website at www.MarillacHealth.org

Medical information about you and your health is private. We strive to protect your health records when you are being seen in the clinics. We will use your records to care for you, bill for care, and to comply with the law.

This Privacy Notice applies to all MarillacHealth clinic services sites. This Notice tells you about the ways MarillacHealth may use or give out information from your private health records. It also explains your rights and responsibilities.

Note: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information.

Who Follows The Terms of This Notice:

- Any health care provider who treats you at any of our locations
- All employees, volunteers, and staff at the hospital and clinics
- Healthcare students in training programs
- Any business associate who performs work for us that requires them to see your medical or dental information to do their jobs

Acknowledgement of Receipt:

I understand that, as allowed and required by law, MarillacHealth staff will use and give out my health records, without my consent or authorization, for:

- Treatment: Care providers will use my health history, symptoms, exams, test results, diagnosis, treatment and plan of care to take care of me.
- Payment: MarillacHealth will use my health records to bill me, my insurance or other aid programs for my care if this applies to the clinic where I receive my care.
- Healthcare Operations: MarillacHealth will use my health records to run the clinics and to make sure patients receive quality care.

Please note that a copy of HIPAA is available upon request for the patient or parent/guardian of a minor receiving medical, dental or mental health counseling services at MarillacHealth. Prior to receiving services, you must sign below, certifying that you understand a copy of our HIPAA policies is available.

Signature of Patient or Legal Guardian	Today's Date
PRINTED Name of Patient or Legal Guardian	Relationship to Patient
Patient Name	Patient DOB