Date/Fecha: _____

Last Name/Apellido:_____ **First Name**/Nombre:_____ **Middle Initial**/Segundo Nombre: ___

Address/Dirección:_____ **City**/Ciudad:_____ **State**/Estado:_____ **Zip Code**/Codigo Postal: _____

S.S.N./Número Social:_____ **Gender**/Género: **M**/Masculino **or**/o **Female**/Femenino **Birthdate**/Fecha de Nacimiento: _____

Home/Teléfono: (___) _____ **Cell**/Número (___) _____ **Email**/Correo Electrónico _____

Best Time and Place to reach you/Mejor lugar y tiempo para contactarlo: _____**Preferred Pharmacy**/Farmacia Preferida:_____

GENDER/SEXUAL ORIENTATION / GENERO/SEXO ORIENTACION

Race: _____
(Example: Black, White, Hispanic, Asian, Indian, Arabic, Other)

Gender Identity/ Género: _____
(Example: Male, Female, Transgender Male, Transgender Female, Gender Non-conforming)

Sexual Orientation/ Sexo: _____
(Example: Straight, Bisexual, Lesbian, Gay, Other, Don't know, choose not to disclose)

PATIENT INCOME INFORMATION / INFORMACIÓN DE INGRESOS DEL PACIENTE

(Please provide proof of income- i.e Check Stub, Letter from Employer, W-2, Tax Return, Award Letter)/
(Proveer prueba de ingreso - i.e Talón del Cheque, Carta del Patrón, W-2, Planilla de Impuestos, Premio Letra)

Company Name/Address (Nombre de la Compañía/Dirección) _____
Employment Income Amount/Ingresos de Empleo $ ☐ Weekly/Semanal ☐ BiWeekly/Cada Dos Semanas ☐ Semi-Monthly/Semi-Mensual ☐ Monthly/Mensual

Other Income/Otros Ingresos $_____ ☐ Weekly/Semanal ☐ BiWeekly/Cada Dos Semanas ☐ Semi-Monthly/Semi-Mensual ☐ Monthly/Mensual

Are you/Eres: ☐ **Married**/Casado ☐**Widowed**/Viudo(a) ☐ **Single**/Soltero(a) ☐ **Minor**/Menor ☐ **Separated**/Separado ☐ **Divorced**/Divorciado

☐ **Partnered for# of___ years**/ Con Compañero(a) Anos Juntos

Are you a Veteran/Eres Veterano: **Yes**/Si **No** **Are you a US Citizen**/Eres Ciudadano **Yes**/Si **No** **If no, permanent resident #** _____
Síno, eres residente # :

SPOUSE/GUARDIAN/PERSON OF SUPPORT INFORMATION-
INFORMACION DE INGRESOS DE ESPOSO(A)/GUARDIÁN/PERSONA

Spouse's/Guardian Name - Nombre de Esposo(a)/Guardián _____

Home/Teléfono (___) _____ **Cell**/Número de Celular (_____) _____

Birthdate/Fecha de Nacimiento:_____ **S.S.N.**/Número Social: _____
Occupation/Occupación:_____

Employer/School Address - Dirección del Empleador/Escuela: _____
Employer/School Phone# - Número del Empleador/Escuela:(___) _____

Employment Income Amount/Ingresos de Empleo $ _ ☐ Weekly/Semanal ☐**BiWeekly**/Cada Dos Semanas ☐ Semi-Monthly/Semi-Mensual ☐ Monthly/Mensual

Other Income/Otros Ingresos $_____ ☐ Weekly/Semanal ☐ BiWeekly/Cada Dos Semanas ☐ Semi-Monthly/Semi-Mensual ☐ Monthly/Mensual

IN CASE OF EMERGENCY, WHO MAY WE CONTACT ON YOUR BEHALF/ CONTACTOS EN CASO DE EMEGENCIA

Name/Nombre:_____ **Relationship**/Relación con el paciente: _____

Home/Teléfono: (____)_____ **Cell**/Número de Celular: (___) _____

CURRENT HOUSEHOLD COMPOSITION-

(starting with yourself and only those persons living at this address for whom you have complete financial responsibility)/

COMPOSICION DE LA FAMILIA-

(Compezando con usted y sólo las personas que viven en esta dirección para quien tiene la responsabilidad financiera complete)

Name/Nombre	Relationship/Relación	Date of Birth / Fecha de Nacimiento	Gender/ Género	Race/ Raza	S.S.N./ Número Social

HOW DID YOU HEAR ABOUT US? PLEASE CIRCLE ONE/ COMO SE ENTERARON DE LOS SERVICIOS DE LA CLÍNICA, POR FAVOR MARQUE UNO

▫ **Commercial/**Comercial ▫ **Radio** ▫ **Patient(Name)/**Paciente(Nombre)_____ ▫ **Other(List)/**Otro(Listo) _____

INSURANCE INFORMATION (please provide copy of insurance card) / INFORMACIÓN SEGURO (por favor presentar la tarjeta de seguro)

Who is responsible for this account?/Quien es responsiblé por la cuenta? _____

Relationship to Patient/Relación de paciente: _____

Is patient covered by additional insurance?/Tiene el paciente seguro adicional? **Yes/**Si **No**

Insurance Company/Compañia Seguro:_____ **Group Number/#** del Grupo:_____ **Policy Number/#** de la Póliza:

Subscriber's Name/Asegurado:_____ **Birthdate/**Fecha de Nacimiento:_____ **S.S.N./**Número Social:

To the best of my knowledge, the above information is complete and correct. I understand that It is my responsibility to inform my doctor if I, or my minor child, ever have a change in personal information,income, or health.

Para mi mejor conocimiento, la información consignada es completa y correcta. Entiendo que es mi responsabilidad de informar a mi médico sí yo o mi hijo menor de edad, alguna vez tenga un cambio en la información personal, ingresos, o la salud.

_____

Signature of Patient, Guardian or Personal Representative
Firma del Paciente,Guardián si es menor de edad, o Representante Personal

_____

Please print name of Patient, Parent, Guardian or Personal Representative
Imprima el nombre del Paciente, Padres, Guardián o Representante Personal

_____

Witnessed By(InclusivCare Employee)
Testigo (InclusivCare Employee)

PATIENT PORTAL ENROLLMENT FORM

What is patient portal?
Patient Portal is a free, Internet based system that allows you to have electronic access to your health information. Patient Portal allows you, as the patient, to:

- Access your medical records online
- Update your contact information

Please note: All information provided to you through Patient Portal is general and should not be considered as, or take the place of, a diagnosis, medical consultation or doctor visit.

How do I enroll?
When you register for Patient Portal, you will provide InclusivCare with a personal, non-shared e-mail address. "Non-shared" means that only you have access to the e-mail address. It is not an e-mail address that you share with your spouse, son, daughter, or any other person.

How does it work?
We will send you an e-mail that contains a link to Patient Portal. After clicking on the link, the Portal page will open. You will be prompted to enter your personal information to verify your identity. Once your identity has been verified, you will have access to Patient Portal.

Is my personal health information protected in Patient Portal?
Patient Portal is in compliance with all patient privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Your personal health information will never be shared with any other person or organization, unless you authorize disclosure in writing or disclosure is permitted by patient privacy law.

Getting Started
Your e-mail address is the first step in your enrollment in Patient Portal. If you are interested in Patient Portal, we require you to enroll with a non-shared (not even with family members or friends), personal (work e-mail is not considered personal) e-mail address. If a family member or friend has access to your e-mail and knows your personal information (date of birth, zip code, social security number, etc.), that person may access your personal health information in Patient Portal. Therefore, we require that you submit only a personal, non-shared e-mail address.

If you would like to enroll, please check the appropriate box below and sign the attached Authorization and Acknowledgement form.

Please note: You are not required to enroll in Patient Portal to continue to receive care at InclusivCare.

- ☐ Yes, I want to enroll in Patient Portal.
- ☐ No I do not want to enroll in Patient Portal

My personal, non-shared e-mail address is: _____

Patient Portal Authorization
In order to enroll in Patient Portal and have access to your personal health information in electronic format, we ask that you read and sign the Acknowledgement below.

Initial: _____

Acknowledgement

I understand that as a patient, I have the right to the privacy of my personal health information under HIPAA. I understand that by enrolling in Patient Portal and giving InclusivCare my e-mail address, I will be given electronic access to my personal health information. I also understand that any person who has access to my e-mail address and my personal information could gain access to my personal health information through Patient Portal. I understand that it is my responsibility alone to restrict access to my e-mail address and personal information to prevent others from accessing my personal health information through Patient Portal. I understand that I am not obligated or required to enroll in Patient Portal or give InclusivCare my e-mail address to continue to receive care from InclusivCare.

_____ _____ _____

Patient's Printed Name | Patient's Signature | Date

Sliding Fee Discount Application

It is the policy of InclusivCare, to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months upon change in financial status.

NAME OF HEAD OF HOUSEHOLD/PATIENT			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

Signature

Date

Form Sliding Fee Application Revised: 07/19

INCLUSIVCARE, INC.

GENERAL CONSENT FOR TREATMENT-Rev.07/

General Consent for Treatment

I request and authorize healthcare and/or dental services by my Provider and his/her designee(s) as my Provider may deem advisable and in my best interest. This may include routine diagnostic, radiology, and laboratory procedures, including screening for diabetes, cholesterol and HIV, and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure. Informed consent means the Provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment. This understanding includes that no research or experimental procedures may be done without my knowledge and consent.

Release of Medical Information

I consent to InclusivCare's use of my health information related to the medical/dental services provided for the following purposes: my treatment, obtaining and determining payment for medical/dental services and for healthcare operations for InclusivCare or other treating providers, all as permitted under federal and state laws and regulations.

Sharing Information with Family and/or Friends
As a courtesy, limited health information may be shared with family, friends and authorized representatives under the following conditions: (1) the information is related to patient care or payment for care, or (2) the information is needed to notify individuals about the patient's location, general condition or death. If you prefer InclusivCare not share this information, please initial below.
Information may be shared with:

Name: _____: Relationship: _____
Name: _____: Relationship: _____
Name: _____: Relationship: _____
_____ (initial) I do not want personal health information shared with family, friends, and/or representatives.

Payment

I assign and authorize payment, for any and all services rendered, directly to InclusivCare from my insurance company or third party payer including, but not limited to: **Medicare, Medicaid or Medicaid Special Product, Commercial Health Insurance, and Workers Disability Compensation Insurance**.

In consideration of the health care services provided to me, I agree to pay for all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments, and non-covered services. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges.

Privacy Practices and Patient Rights and Responsibilities

InclusivCare's provides information about how health information may be used and disclosed. I, the patient, or his/her legal representative, acknowledges that I have been offered an opportunity to review the Privacy Practices before signing this form. I, the patient, or his/her legal representative, also acknowledges that I have received a copy of the "Patient Rights and Responsibilities" before signing this form.

Office Use Only: I explained Confidential Billing to the patient. The patient ❑Accepted ❑Declined

❑ **REPRODUCTIVE HEALTH SERVICES (Family Planning, STI, & HIV Services)**

By checking this box, I am indicating that I understand that it is my choice to use reproductive health services, that I cannot be forced to receive services nor to use any particular method of family planning, that my information will be kept private, and that my information may not be shared without my consent except as required by law. The sliding fee scale has been explained to me, and I understand that if I do not have insurance or do not want to use my insurance, I will be charged for services based on my household income. **I also understand I will not be refused services based on inability to pay.**

Revised:07/2019

INCLUSIVCARE, INC.

GENERAL CONSENT FOR TREATMENT

Communication

I agree that InclusivCare may communicate with me in writing to any address I have provided, may communicate with me orally or by text message to any phone number I have provided, and may communicate with me electronically to any email address that I have provided.

Communication will be based on my preference:

My preferred method of communications is (please circle): Cell phone Home phone Work phone

Appointments/normal test results may be left on my answering machine/voice mail (please circle): Yes No

Appointment information may be sent to me via text message to my cell phone (please circle): Yes No

I have read the consent form, or it has been read to me, and I am satisfied that I understand its content. My questions have been answered to my satisfaction.

_____ _____/_____/_____

Patient Name (Print) Date

_____

Patient Signature or Legal Representative

What is an advance directive?

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions. Advance directives can take many forms. Laws about advance directives are different in each state. You should be aware of the laws in your state.

What is a living will?

A living will is one type of advance directive. It is a written, legal document that spells out medical treatments you would and would not want to be used to be used to keep you alive, as well as other decisions such as pain management or organ donation.

In determining your wishes, think about your values, such as the importance to you of being independent and self-sufficient, and what you feel would make your life not worth living. Would you want treatment to extend life in any situation? Would you want treatment only if a cure is possible?

Have discussions with your primary care doctor, your health care agent, family and friends about your personal wishes. Resources for organizing your own thoughts and having conversations with others about medical care and end-of-life care are available through the American Bar Association, the Conversation Project and the Center for Practical Bioethics.

You should address a number of possible end-of-life care decisions in your living will Here are some examples:

- **Resuscitation** restarts the heart when it has stopped beating. Determine if and when you want to be resuscitated by cardiopulmonary resuscitation (CPR) or by a device that delivers an electric shock to stimulate the heart.

- **Mechanical ventilation** takes over your breathing if you are unable to do so. Consider if, when and for how long you would want to be placed on a mechanical ventilator.

- **Tube feeding** supplies the body with nutrients and fluids intravenously or via a tube in the stomach. Decide if, when and for how long you would want to receive this treatment.

- **Organ and tissue donations** for transplantation can be specified in your living will. If your organs are removed for donation, you will be kept on life-sustaining- treatment temporarily until the procedure is complete. To help your agent avoid and confusion, you may want to state in your living will that you understand the need for this temporary intervention.

What is a do not resuscitate order?

A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. You don't need to have an advance directive or living will to have do not resuscitate (DNR) and do not intubate DNI) orders., If you have a living will, however, be sure to mention if you have a DNR or DNI order on file.

Points to remember about Advance Directive

- Include your loved ones in Advance Directives discussion and decision making
- Your physician and health care facility representative should also be consulted.
- Inform people, such as your family, close friends, and physician, about your Advance Directive
- If desired, you can fill out both a living will and a durable power of attorney for healthcare.
- A lawyer generally is not necessary for filling out an Advance Directive.
- An Advance Directive can be changed or revoked at any time.
- Advance Directive have no effect until the time when you can no longer make or communicate decisions for yourself.
- Advance Directives expand your decision-making power and your control your care.
- Find forms at www.everplans.com/artiticles.louisiana-advance-directive-forms

It is the policy of Inclusivcare employees and providers will stabilize, through appropriate measures, any patients that are in our facility. Those patients will then be transported via EMS to the nearest hospital. The EMS transport team will be given a copy of the patients Advance Directive. It is at this point that the determination of enforcement of the advance directive can be made in a hospital setting.
Signing below acknowledges receipt of this policy and consent to treatment with this policy in effect

_____ _____

Signature **Date**

Revised

Self Declaration

I_____, am declaring that I do not have proof of income/address at this time yet
Patient Name

will provide the requested documentation within 15 days of the date of service. I understand that I

will only be allowed this one visit on_____ on a Sliding Fee A Discount and any
Date of Service

subsequent visits here after without proper documentation will be set at full price for any services

rendered and all associated fees will be due at time of service.

_____ _____
Patient Signature & Date Staff Signature & Date

Promissory Note

I_____, understand that my portion of the responsibility for the Healthcare
Patient **Name**

Services rendered by InclusivCare, Inc. to me on _____ amounted to $_____
Date **of** Service Balance Due

and I am expected to pay this balance within 30 days of the date of service.

Today's Balance	$_____
Previous Balance	$_____
Total Balance Due	$_____

_____
Patient Signature & Date

_____
Staff **Signature & Date**

_____
Witness Signature