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 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
Monday-Friday
8:00 – 11:45 AM
12:45 – 5:00 PM

Evening Hours
By Appointment

Walk In Hours
Monday-Friday
8:00 – 10:30 AM
1:00 – 3:00 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 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 the option 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 volumes of calls, it may take 48 hours before the medicine is ready for pick up. Your call is very important to us.

Lab Hours- Monday – Friday- 8:00 - 11:00 A.M. or 1:00 - 3:00 P.M.

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:

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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

Military □ 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_____

Please √ all that apply: □ May discuss my medical info □ May pick up my medications

Address_____
Street City State Zip

Name _____ Relationship _____ Phone_____

Please √ all that apply: □ May discuss my medical info □ May pick up my medications

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 health care options. 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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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:

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) (Phone Number)

_____ _____

(Printed Name of Personal Representative) (Phone Number)

_____ _____

(Printed Name of Personal Representative) (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).

Expiration 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 Practice 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, INC

Health Questionnaire

Patient Name: _____ Birth Date: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, may affect your oral health.

Are you under a physicians' care now?	○ Yes	○ No
If yes _____		
Have you ever been hospitalized or had a major operation?	○ Yes	○ No
If yes _____		
Have you ever had a serious head or neck injury?	○ Yes	○ No
If yes_____		
Are you taking any medications, pills, or drugs?	○ Yes	○ No
If yes _____		
Are you taking any blood thinners?	○ Yes	○ No
If yes _____		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	○ No
If yes _____		
Do you use tobacco?	○ Yes	○ No
If yes _____		
Do you use controlled substances?	○ Yes	○ No
If yes _____		

Women: Are You ....

○ Pregnant/Trying to get pregnant?	○ Nursing?	○ Taking oral contraceptives?

Are you allergic to any of the following?

○ Aspirin	○ Penicillin	○ Codeine	○ Acrylic
○ Metal	○ Latex	○ Sulfa Drugs	○ Local Anesthetics
○ Silver	○ Red Dye	○ Iodine	○ NONE
	○ Other?		

If yes _____

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

AIDS/HIV Positive	Yes O No O	Cortisone Medicine	Yes O No O	Hemophilia	Yes O No O	Radiation Treatment	Yes O No O
Alzheimer's Disease	Yes O No O	Diabetes	Yes O No O	Hepatitis A	Yes O No O	Hepatitis B or C	Yes O No O
Anaphylaxis	Yes O No O	Drug Addiction	Yes O No O	Renal Dialysis	Yes O No O	Anemia	Yes O No O
Herpes	Yes O No O	Rheumatic Fever	Yes O No O	Angina	Yes O No O	Emphysema	Yes O No O
High Blood Pressure	Yes O No O	Arthritis	Yes O No O	Epilepsy or Seizures	Yes O No O	Scarlet Fever	Yes O No O
Artificial Heart Valve	Yes O No O	Excessive Bleeding	Yes O No O	Hives or Rash	Yes O No O	Shingles	Yes O No O
Artificial Joint	Yes O No O	Excessive Thirst	Yes O No O	Hypoglycemia	Yes O No O	Sickle Cell Disease	Yes O No O
Asthma	Yes O No O	Fainting Spells/Dizziness	Yes O No O	Irregular Heartbeat	Yes O No O	Sinus Trouble	Yes O No O
Blood Disease	Yes O No O	Kidney Problems	Yes O No O	Spina Bifida	Yes O No O	Blood Transfusion	Yes O No O
Leukemia	Yes O No O	Stomach/Intestinal	Yes O No O	Breathing Problems	Yes O No O	Frequent Headaches	Yes O No O
Liver Disease	Yes O No O	Stroke	Yes O No O	Bruise Easily	Yes O No O	Low Blood Pressure	Yes O No O
Swelling of Limbs	Yes O No O	Cancer	Yes O No O	Glaucoma	Yes O No O	Lung Disease	Yes O No O
Thyroid Disease	Yes O No O	Chemotherapy	Yes O No O	Mitral Valve Prolapse	Yes O No O	Tonsillitis	Yes O No O
Chest Pains	Yes O No O	Heart Attack/Failure	Yes O No O	Osteoporosis	Yes O No O	Tuberculosis	Yes O No O
Cold Sores/Fever blisters	Yes O No O	Heart Murmur	Yes O No O	Pain in Jaw Joints	Yes O No O	Congenital Heart Disorder	Yes O No O
Heart Pacemaker	Yes O No O	Parathyroid Disease	Yes O No O	Convulsions	Yes O No O	Heart Trouble/Disease	Yes O No O
Psychiatric Care	Yes O No O	Venereal Disease	Yes O No O	Yellow Jaundice	Yes O No O	Recent Weight Loss	Yes O No O

Have you ever had any serious illness not listed above? O Yes O No If yes _____

If any blood relative has suffered any of the above, please list below.

_____

_____

_____

_____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the dental/medical staff if I, or my minor child, ever have a change in medical or dental health. I give my consent for the Well Care Community Health, Inc. to use and disclose my protected health information (PHI) for treatment, payment, and health care options (TPO). I have received a copy of the Notice of Privacy Practices. The Clinic 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 the Clinic to restrict how it uses or discloses my PHI, however, the practice is not required to agree to my restrictions.

X _____ _____

Signature of Patient, Patient or Guardian Date

X_____

Relationship to Patient if signed by Guardian

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Community Health

your choice for better care

Medical
Dental
Behavioral

Patient Consent for Care Form

Consent to Care:

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, year 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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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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