WV Health Right Patient Eligibility Form

NAME ______________________________
Last First Middle Initial Maiden Name

ADDRESS ______________________________
Street Address or PO Box

____
City County State Zip Code

PHONE ______________________________
Include Area Codes Home Work Cell

EMAIL ADDRESS ______________________________

EMERGENCY CONTACT PHONE # ______________________________

LANGUAGE : ☐ENGLISH ☐ SPANISH ☐FRENCH ☐ OTHER____________

Preferred method of contact: ☐Phone ☐email ☐ Mail ☐ Ok to leave message

BIRTH DATE:

SOC. SEC. #:

Are you employed? ☐ **YES** ☐ **NO**
If YES, Where?

Marital Status
☐ Married
☐ Single
☐ Widowed
☐ Divorced

Race
White☐ Black☐ Asian ☐
Am. Indian/Alaskan ☐
Hawaiian/Pacific Islander ☐
Two or more Race ☐

Hispanic?
Yes ☐
No ☐

Sex
Female ☐
Male ☐

Homeless Status
☐ Shelter
☐ Street
☐ Living with a friend or relative

Have you been to an ER in past year? YES ☐ **NO** ☐
If YES, # of times to the ER: _________
If YES, Name of Hospital ER:

DRUG ALLERGIES? YES☐ **NO** ☐
If YES , LIST:

Do you have a regular doctor? If yes, who? YES ☐**NO** ☐

Physician's Name: ______________________________

Last Grade of School Completed: ☐

Medical Insurance Status
____ Have you APPLIED for Medicaid
____ Veterans (V.A.)
____ Medicaid (white card from the State *of WV*)
____ Private Ins: ______________
____ Medicare (red/white/blue card)
____ No Insurance

IMPORTANT: The section below deals with TOTAL Household information, proof of income must be provided annually and this form updated annually.

# of People in the household: ☐

WITHOUT this clinic, what would your medications cost you monthly **(please estimate)** **$** __________

List the full name & age of ALL house members and their income.	Age	Wages/ Pay period	Social Sec. Disability	Retirement	Workers Comp/	Veterans/& Other	TOTAL MONTHLY
Your Information ⇨		$	$	$	$	$	$
		$	$	$	$	$	$
		$	$	$	$	$	$
		$	$	$	$	$	$
Total Household income		$	$	$	$	$	$

PATIENT AGREEMENT / DISCLOSURE : I agree to allow WV Health Right to complete any patient assistance program enrollment process on my behalf, which may include disclosure of personal & medical information, soft credit check and other information necessary to determine eligibility for available drug manufacturer programs to secure my prescribed medication. Your information is confidential and secure, and only available to licensed prescribers, WV Health Right pharmacy and Administrative staff. By signing this form I attest that this information is true and accurate. I also agree that if I enroll with any medical insurer (including but not limited to Medicaid & Medicare programs) or if my financial situation changes that I will immediately notify WV Health Right. I also agree to allow pharmaceutical company auditors to review my information as needed for participation in patient assistance programs.

____
Signature date

WVHR Staff to complete this section

	Date	Initials
Form Completed	____	____
HIPAA Form	____	____
POI Told	____	____
IRS Form	____	____
POI rec'd 2015	____	____
Photo ID	____	____

Form Updated 12/2013

WEST VIRGINIA HEALTH RIGHT, INC
PATIENT INTAKE QUESTIONNAIRE
Please complete this form (both sides)

Name________________________
Date of Birth________ Age______
Race: Asian Black Hispanic White American Indian
Last grade level completed: ________

I consider myself to be in **GOOD FAIR POOR** health. (Circle one)
Are you allergic to any medications? (Y) (N) If Yes, list:________________________
If you are allergic, what was your reaction to the medicine like? ________________________

__PERSONAL HABITS__: Do you have any of the following habits?

Yes	No	
☐	☐	**Smoke Tobacco?** If yes, how many packs per day? ___ Age started___ Desire to quit? (Y) (N)
☐	☐	**Chew Tobacco?** If yes, what type:__________ How much?_______ Desire to quit? (Y)(N)
☐	☐	**Body Piercing?** If yes, where?________________ How many?________
☐	☐	**Have tattoos?** If yes, where ________________ Who put them on? Friend or Professional
☐	☐	**"Shot up" drugs?** If yes, when was the last time?_______ Which Drugs?______________
☐	☐	**Used other drugs?** If yes, when was the last time?_________ Which Drugs?____________
☐	☐	**Drink Caffeine?** If yes, how much? Coffee_____ Soda_______ Tea______ Other__________
☐	☐	**Drink Alcohol?** If yes, how much?________________ Number of times **this** week_________
☐	☐	**Practice safe sex?** If not, why?________________________
☐	☐	**Told you could NOT give blood or plasma?** If yes, when________________________

__FAMILY HISTORY:__ Who in your immediate family has had the following health problems?
__GM__ (Grandmother), __GF__ (Grandfather), (__F__)ather, (__M__)other, (__A__)unt, (__U__)ncle.
(List all that apply)

Substance abuse? **Alcohol** ________ **Drugs**_______
Cancer? ____________ *Type*:______________
Diabetes/Sugar? ________________________
Heart Problems? ________________________
High Blood Pressure? ________________________
Kidney Problems ?________________________

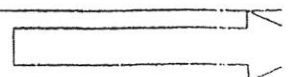
Asthma? ________________________
Migraines? ________________________
Depression/nervous? ________________
Seizures? ________________________
Bleeding Diseases? ________________
Thyroid problems? ________________

__YOUR__ MEDICAL HISTORY:
I have problems with my health in the following ways (check all that apply):

☐ Anxiety	☐ Depression	☐ Drug Dependence
☐ High Blood Pressure	☐ Heart Attack	☐ Blood Clots
☐ Asthma	☐ Black Lung	☐ Emphysema (Smokers Lungs)
☐ Pneumonia	☐ Tuberculosis	☐ Hepatitis (sore liver)
☐ Stomach/Heartburn	☐ Rectal bleeding	☐ Diabetes (type)______________
☐ Cancer (Where__________)	☐ Bone problems	☐ Skin Infections
☐ Gum/Tooth decay	☐ Eye problems	☐ Hearing problems
☐ Sexual problems	☐ Bladder infections	☐ Kidney stones/infections
☐ Breast lump	☐ Testicular Lump	☐ Blood Transfusions (What year?______

__WOMEN ONLY:__
Date last Pap test? _______ Date of last mammogram? ______ Could you be pregnant today? (Y) (N)
Are you menopausal? (change of life) (Y) (N) Do you use birth control? (Y) (N) Type? __________
Hysterectomy?_______Partial or Complete?_________Was hysterectomy done for cancer?__________
Date last menstrual cycle started?_______ Do you do a self breast exam? (Y) (N)
How many times pregnant?_____ Number live births?______ Vaginal Birth (Y) (N) C-Section (Y) (N
Tubal Ligation? (Y) (N) Date_______

TURN PAGE OVER TO COMPLETE THE QUESTIONS, PLEASE!



MEDICATIONS PRESCRIBED BY YOUR DOCTOR OR OTHER PROVIDER:

Drug Name	Dosage	How often taken	Last time taken

OVER THE COUNTER MEDICATIONS AND HOME REMEDIES

Medicine Name	Dosage	How often taken	Last dose taken

HOSPITALIZATIONS AND SURGERY

Reason	Dates	Reason	Dates

If there are any other concerns you have that you think may affect your care at WV Health Right please write them down here.

____
____
____
____
____
____
____

Thank you.

I give my permission to be examined and treated by Health Right providers and agree to do my part to follow the medical plan recommended to me by the Health Right staff.

Patient Signature_______________________________ Date _______ Time_______

My Files/patient info/patient intake questionnaire 8/2001

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164)

1. **Authorization:**
   I authorize WV Health Right, Inc. to use and disclose the protected health information to____ (names of people).
2. **Effective Period:**
   The authorization for release of information covers the period of healthcare from:
   (a) ☐ __________to_____________ *****OR****** (b) ☐ all past, present & future.
3. **Extent of Authorization:**
   (a) ☐ I authorize the release of my complete health record **including** records related To mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

   OR

   (b) I authorize the release of my complete health record with the **exception** of the following information:
   - ☐ Mental health records
   - ☐ Communicable diseases (including HIV & AIDS)
   - ☐ Alcohol/drug abuse treatment
   - ☐ Other(please specify)____
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until ___________(Date) at which time this authorization expires **OR** ☐ PERMANENTLY (no expiration date).
6. I understand that I have a right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, enrollment, or eligibility for treatment will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

________________________________/________	__________________________/________
Signature of Patient or Legal Representative /Date	**Print Name of patient/Date of Birth**

CONSENT FOR TREATMENT

PATIENT NAME____DOB_____________________

GENERAL CONSENT FOR TREATMENT

I request and authorize health care 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 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.

RELEASE OF MEDICAL INFORMATION

This form has been fully explained to me, and I understand its content and significance. I consent to West Virginia Health Right to use my health information related to the medical services provided for the following purposes: my treatment, obtaining payment for the medical services and for health care operations of West Virginia Health Right or other treating providers all as permitted under federal and state laws and regulations.

____ ____________________

Signature of Patient — Date

____ ____________________

Signature of Legal Representative (if patient is unable to sign) — Relationship to Patient

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I certify that I have received a copy of the Privacy Practice Notice for WV Health Right, WVRx/IHope. The notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills by insurance companies or in the operations of WV Health Right, WVRx/IHope. The notice also describes my rights and the obligation of WV Health Right, WVRx/IHope to respect the privacy of my protected health information. The Notice of Privacy is also posted in the waiting room and is available at the front desk upon request.

Name:____

Signature:____

Date:____________