WV Health Right Patient Eligibility Form

NAME ____________________________
Last First Middle Initial Preferred 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** ☐

VETERAN YES ☐ **NO** ☐ **ARE YOU PREGNANT YES** ☐ **NO** ☐

BIRTH DATE:

SOC. SEC. #:

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

Marital Status
- Married ☐
- Single ☐
- Widowed ☐
- Divorced ☐

Race
- Caucasian ☐
- African American ☐
- Asian ☐ Am. Indian/Alaskan ☐
- Hawaiian/Pacific Islander ☐

Hispanic?
- Yes ☐
- No ☐

Sex
- Female ☐
- Male ☐
- Other ☐

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 Input Status

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 <u>Household</u> 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/ Unemployment	Veterans/& Other	TOTAL MONTHLY
Your Information ⇨		$	$	$	$	$	$
		$	$	$	$	$	$
		$	$	$	$	$	$
		$	$	$	$	$	$
Total Household income		$	$	$	$	$	$

<u>PATIENT AGREEMENT / DISCLOSURE</u> : 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

<u>WVHR Staff to complete this section</u>

	Date	Initials
Form Completed	________	_____
HIPAA Form	________	_____
POI Told	________	_____
POI	________	_____
Photo ID	________	_____

Form Updated 12/2021

Medical History

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER
CITY, STATE ZIP		
HOME PHONE	MOBILE PHONE	DATE OF BIRTH

Do you have or have you had any of the following? Check all that apply.

- ☐ Artificial Joints
- ☐ Heart Issues (circle all that apply)
  - Murmur
  - High Blood Pressure
  - Low Blood Pressure
  - Tobacco
  - Pacemaker
  - Rheumatic Fever
- ☐ Blood Transfusion
- ☐ Anemia
- ☐ Clotting Disorder
- ☐ Abnormal Bleeding
- ☐ Thyroid Problem
- ☐ Kidney Disease
- ☐ Tuberculosis
- ☐ Autoimmune Disorder
- ☐ HIV
- ☐ Neurologic Disorder
- ☐ Seizure, Epilepsy, Fainting
- ☐ Arthritis
- ☐ Cancer or Tumor
- ☐ Migraines/Headaches
- ☐ Asthma
- ☐ Herpes or Cold Sores

Are you : ☐ Pregnant ☐ Taking Hormones

Reason for dental visit:

____

____

Are you allergic to any of the following?

- ☐ Latex
- ☐ Anesthetic (Lidocaine or Novacaine)
- ☐ Antibiotics
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Other______________

Are you using or taking any of the following?

- ☐ Tobacco
- ☐ Aspirin
- ☐ Antibiotics
- ☐ Blood Thinners
- ☐ Osteoporosis Meds
- ☐ Insulin
- ☐ Nitroglycerin
- ☐ Non-Precrisption Drugs
- ☐ Other______________

Contract for Dental Services

All patients must agree to the following conditions in order to receive dental services at West Virginia Health Right.

NARCOTICS are not provided or prescribed at West Virginia Health Right. Non-narcotic medications will be offered for pain relief and have been shown to be effective in pain management.

SLEEP ANESTHESIA is not offered at this clinic. The dentists are gentle and will assist in making you as comfortable as possible throughout the procedure(s).

ORAL HYGIENE must be practiced. We will show you how to take care of your teeth and gums after the procedures we provide. If you do not follow our instructions, we will not schedule you for additional dental work.

NO SHOW or late cancellations: We understand that there are some circumstances that might cause you to miss your appointment. Therefore, if you must cancel an appointment, you must do so at least 48 hours in advance so that another patient may fill your space. Two missed appointments may result in dismissal from the dental program. Call (304) 414-5915 for cancellations.

I agree with the above, and will do my best to comply so that the complications I may experience as a result of any dental procedure I will have, will be minimized.

Patient Signature:______________________________ **Date:**______________

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**