Compass Health Network

WELCOME

We are here to help!

To better assist you, we ask that you please answer the following questions along with the other forms in this packet.

Last Name: _____ **First Name**: _____**Middle Name**: _____

Alias: _____(nickname/prior name) **Date Form Completed**: _____

Client Social Security Number: _____ **Client Date of Birth**: _____

Birth Sex (Assigned at Birth): ☐Female ☐ Male

Client Address: _____

City, State, Zip: _____

Marital Status: _____ **Preferred Language:** _____

Smoker: ☐Yes ☐ No

Client Home Number: _____ **Client Cell Phone:** _____

Client Email Address: _____

Preferred Contact Method: ☐Home ☐Cell ☐ Email

Notifications for automated appointment reminders: (select only one)
☐ Email
☐ SMS (Text)
☐ Voice Reminders
☐ Opt out

Medical Insurance: _____(Provide insurance card to front desk staff.)

Dental Insurance: _____(Provide insurance card to front desk staff.)

Emergency Contact Name: _____

Phone Number: _____

Emergency Contact Relationship to Client:_____

Parent/Guardian (s)	Parent/Guardian 1	Parent/Guardian 2
Name:		
Relationship:		
Address:		
Phone		

Homeless Status:
☐ Non Homeless
☐ Homeless Shelter
☐ Doubling Up (living with others, "couch surfing")
☐ Transitional Housing (small unit where people transition from a shelter)
☐ Street (living on street, vehicle, outdoors, or encampment)
☐ Other (reside in hotel/motel)

Migrant Worker Status:
☐ Migrant
☐ Not a Farm Worker
☐ Seasonal Agricultural Worker or Dependent

Language Barrier: ☐ Yes ☐No

Race: (check all that apply)

☐ American Indian or Alaska Native	☐ Guamanian or Chamorro	☐ Other Pacific Islander
☐ Asian Indian	☐ Japanese	☐ Samoan
☐ Black or African American	☐ Korean	☐ Vietnamese
☐ Chinese	☐ Native Hawaiian	☐ White
☐ Filipino	☐ Other Asian	☐ Unreported/Refused to Report

Ethnicity:
☐ Cuban
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Another Hispanic, Latino/a, or Spanish origin
☐ Not Hispanic or Latino/a
☐ Declined to specify

Veteran Status: ☐ Yes ☐No

Head of Household
☐ Self

If not self, Relationship to Patient _____

Head of Household Name:_____

Head of Household DOB:_____**Head of Household Birth Sex**:_____

Head of Household Address:_____ **City, State, Zip :** _____

Phone Number: _____

Number in Household: _____

Annual Income Range:

☐ $0 - $13,590
☐ $13,591 - $18,310
☐ $18,311 - $23,030
☐ $23,031 - $27,750
☐ $27,751 - $32,470
☐ $32,471 - $37,190
☐ $37,191 - $41,910
☐ $41,911 - $46,630
☐ $46,631 & above

How were you referred to Compass Health Network? Marketing Plan:

☐ Agency
☐ Billboard
☐ Friend or Family
☐ Internet
☐ Newspaper
☐ Other Health Provider
☐ Radio
☐ TV
☐ Other**:**_____

Compass Health Network

Patient Name: _____ Date of Birth: _____

COMPASS HEALTH NETWORK
Medical and Dental Health Services
Consent for Services

I **give consent to Compass Health Network to provide me or my minor child medical and/or dental services.**
I understand the policies regarding appointment cancellations and payment and I give permission for payment of Insurance benefits to be made directly to Compass Health Network for any services rendered.

I understand that I am financially responsible for all charges, and that payment is due at time of service. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize Compass Health Network to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Authorization for Protected Health Information (PHI) during your appointment.
To access copies of lab results, x-ray reports, medication list and obtain physical or release to school/work forms completed I give consent for Compass Health Network to release that information. Furthermore, referral to specialty care may include current documentation to best coordinate your care. When requesting a full or partial medical record to be released to another party or to yourself requires a Release of Information be completed and processed through medical records.

I acknowledge by my signature below that I have received a copy of Compass Health Network's Notice of Privacy Practices. I understand that if I have any questions regarding confidentiality, I may contact the Privacy Officer at (660) 890-8141.

Signature: _____ Date:_____

Witness: _____ Date: _____

Compass Health Network

Name: _____
DOB: _____

Medical & Dental Services
Payment and Appointment Policies & Procedures

Compass Health Network has procedures for the handling of missed appointments and late arrivals to ensure continuity of care.

Late Arrival Procedure:
If the patients arriving after the designated time for their appointment, every attempt will be made to see the patient in the time remaining. If more than half of the allotted appointment time has lapsed, the receptionist will check with the provider as to whether their schedule allows them to see the patient or if the patient needs to reschedule. If the patient needs to be rescheduled, a written prescription will be provided per the medication refill policy, if needed.

Every effort will be made to see patients arriving late for an appointment who are in urgent need and not able to be seen by the provider with whom they are scheduled, based on provider availability.

Walk-In Patients:

- Walk-in patients will be seen based on availability.
- Walk-in appointments will not be taken ahead of a scheduled appointment if the patient has arrived on time.
- Patient will be informed of approximately how long they will wait to be seen.
- Patient will be offered option to wait or to schedule an appointment for a later date.
- Patient will be given an appointment card with date time of appointment.

Missed Appointment Procedure:
Policy: Patients are asked to provide us a 24-hour notice if they will be unable to keep their appointment.

Dental: Patients who miss 3 appointments (less than 24-hour notice) in a 12 month period will be notified that they can be seen on a "walk-in" basis for their next visit with a dental provider. Patients on a walk-in status will be told they can call the morning of the day they can make it in, and every attempt will be made to work them in given provider availability. After 1 complete walk-in appointment, the patient may schedule their next appointment.

Medical: Patients who miss 3 appointments (less than 24-hour notice) in a 12 month period will be notified that they can be seen on a "walk-in" basis for their next visit with a medical provider. After 1 complete walk-in appointment, the patient may schedule their next appointment.

Payment & Collection:
Policy: Patients are expected to provide payment, including co-payments associated with insurance and sliding fee payments, at the time of check-in for an appointment.

Patient/Legal Guardian Signature _____ **Date** _____

Witness Signature _____ **Date** _____

Compass Health Network

Patient Name: _____ Date of Birth: _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand and have been provided with a *Notice of Privacy Practices*, which provides a more complete description of information uses and disclosures. I understand I have the right to review the notice prior to signing this consent. I understand Compass Health Network reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand I have the right to object to the use of my health information. I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

Communication Preferences

Please remember that communications through email, text and phone cannot be guaranteed as confidential. By choosing your preferred method of communication(s) above, you acknowledge that Compass Health Network is not liable for any information communicated in these manners.

☐ I agree to allow Compass Health Network to leave message for me when I am unavailable. I understand that messages may contain confidential information.

Method	Number/Address	Messages (YES/NO)
Home Phone	( ) _____	☐ YES ☐ NO
Cell Phone	( ) _____	☐ YES ☐ NO
Work Phone	( ) _____	☐ YES ☐ NO
Alternate Phone	( ) _____	☐ YES ☐ NO
Text Messages	( ) _____	☐ YES ☐ NO
Email	_____	☐ YES ☐ NO

☐ I authorize Compass Health Network to discuss my healthcare information with the contacts listed below. I understand that by leaving spaces blank I am indicating that I do not want any information released to anyone else.

Name	Relationship	Contact #	Emergency Contact	OK to discuss billing information	OK to discuss appointments
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Witness, Title Date

Inspire Hope. Promote Wellness.
compasshealthnetwork.org

Compass Health Network

Name: _____ Date of Birth: _____

Compass Health Network
Financial Policy

Welcome

Thank you for choosing Compass Health Network. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important. We have provided the following information to help you understand your financial responsibility for services received:

If You Have….	You Are Responsible For…
Commercial Insurance or Medicare HMO with which we have a contract	***If the services you receive are not covered by the plan:*** Payment in full is requested at the time of the visit. You will be billed for payments due that are not collected at the time of visit. *
	If you have commercial insurance as primary and have secondary insurance or Medicaid: No payment is necessary at the time of visit.
	If you have commercial insurance as primary, but no secondary insurance: All applicable copays, coinsurance, and deductibles are requested at the time of the office visit.
Medicare	***If the services you receive are not covered by Medicare:*** Payment in full is requested at the time of the visit. You will be billed for payments due that are not collected at time of visit. *
	If you have Regular Medicare, and have not met your $100 deductible, we ask that it be paid at the time of service.
	If you have Medicare as primary and have secondary insurance or Medigap or Medicaid: No payment is necessary at the time of visit
	If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% coinsurance is requested at the time of visit.
Medicaid or Managed Care Medicaid	***If the services you receive are not covered by Medicaid:*** Payment in full is requested at the time of the visit. You will be billed for payments due that are not collected at the time of visit. *
	If you have a Medicaid Spend Down: Payment for services is requested at the time of the visit until the Medicaid Spend Down has been met. No payment is necessary when Spend Down has been met.
	If you have Medicaid without a Spend Down: No payment is necessary at the time of visit.
Commercial Insurance or Medicare HMO – No Compass Contract	Payment in full is requested at the time of service. We can provide you with the necessary information for you to file a claim with your insurance company directly.
No Insurance	Payment in full is requested at the time of service. * Please ask front desk staff for information on applying for Medicaid, CHIP, financial assistance, sliding fee or Department of Mental Health funding.

***** Compass Health Network offers a sliding scale discounted price based on income and household size for which you may be eligible.

_____ (patient/guardian initials) I acknowledge and understand the above financial policy.

3.15.2021

Name: _____ Date of Birth: _____

Insurance

Before your visit, contact your insurance company to verify that Compass Network is a participant in your plan and the services you intend to receive and provider of those services are covered. Not all services or providers are covered by all policies. Services not covered by your insurance plan will be your responsibility.

For us to file a claim, you must present a CURRENT copy of your insurance card at each visit and communicate changes in your personal information.

Information Required at Check In

The following information is required at check in at each visit:

1. Verification of personal contact information
2. Current copy of insurance card
3. Payment of any outstanding balance
4. Payment of Today's visit

Payment can be made via cash, check or card unless service is provided in the field or school, in which you will be expected to come into the nearest office to make payment.

Labs and Prescriptions

Any labs or prescriptions ordered by the physician are not covered by this financial notice and your financial responsibility will be dependent on lab or pharmacy.

I have read, understand, and agree to the above Financial Declaration. I understand that charges not covered by my insurance company, as well as applicable copayments, coinsurance, and deductibles are my responsibility.

_____ _____

Signature of Client Date

_____ _____

Witness Signature Date

Compass Health Network

Patient Medical History

Patient Name:_____ Date of Birth: _____

Primary Care Physician: _____ Facility Name: _____

Date of last exam: _____ Are you under care of a specialist? _____

	Yes	No		Yes	No
1. Are you under medical treatment now by a primary care physician or specialty doctor?	☐	☐	8. Do you use tobacco products?	☐	☐
2. Have you been hospitalized, or have you had any surgeries in the last 5 years? If yes, please explain. _____ _____	☐	☐	9. Do you use a vape?	☐	☐
			10. Do you use controlled substances including marijuana/recreational drugs?	☐	☐
3. Please list all prescription and non-prescription medications you are taking, including any herbal supplements. _____ _____	☐	☐	11. Do you have a history of drug/alcohol abuse?	☐	☐
4. Have you ever taken bisphosphonate therapy (pills or injections for bone strengthening such as Fosamax, Boniva) for osteoporosis or cancer?	☐	☐	12. Are you currently feeling like harming yourself and/or others?	☐	☐
5. Are you currently taking any blood thinners or undergoing anticoagulant therapy? (e.g. Coumadin, Plavix, Eliquis, Aspirin)	☐	☐	***FOR WOMEN ONLY:***		
			Are you pregnant or think you may be? If yes, due date: _____	☐	☐
6. Have you ever had any prolonged bleeding following a surgical procedure including tooth extractions?	☐	☐	***Are you nursing?***	☐	☐
7. Do you have any disabilities? If yes, please explain: _____	☐	☐	***Are you taking oral contraceptives(birth control)?***	☐	☐

Are you allergic to or have you had any reactions to the following?

	Yes	No	If yes, what is the reaction?
Local Anesthetics (e.g. Lidocaine or Septocaine)	☐	☐	
Penicillin/Amoxicillin	☐	☐	
Other Antibiotics	☐	☐	
Other Medications	☐	☐	
Barbiturates	☐	☐	
Sedatives	☐	☐	
Iodine	☐	☐	
Aspirin	☐	☐	
Any metals (e.g. nickel, mercury, etc)	☐	☐	
Latex Rubber	☐	☐	
Codeine	☐	☐	
Red Dye	☐	☐	
Other Allergies:	☐	☐	

_____ *(patient/guardian initials)* I acknowledge that the above information is accurate.

Doctor's Initials ☐ Date ☐

Compass Health Network

Patient Medical History

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

	Yes	No		Yes	No		Yes	No
Mitral Valve Prolapse	☐	☐	Fainting	☐	☐	Arthritis	☐	☐
Heart Disease/Heart Failure	☐	☐	Epilepsy/Convulsions/Seizures	☐	☐	Osteoporosis	☐	☐
Heart Surgery	☐	☐	Cancer	☐	☐	Joint Replacement or Implant	☐	☐
Heart Attack	☐	☐	Leukemia	☐	☐	Back/Neck Problems	☐	☐
Heart Murmur	☐	☐	Radiation Therapy	☐	☐	Thyroid Problem	☐	☐
Chest Pains/Angina	☐	☐	Chemo Radiation Therapy	☐	☐	Kidney Disease	☐	☐
Cardiac Pacemaker	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐
High Blood Pressure	☐	☐	Hay Fever/Allergies	☐	☐	Jaundice	☐	☐
Low Blood Pressure	☐	☐	Respiratory Problem	☐	☐	Stomach/Intestinal Troubles	☐	☐
Stroke	☐	☐	Emphysema/COPD	☐	☐	Acid Reflux	☐	☐
Blood Clots	☐	☐	Asthma	☐	☐	Ulcers	☐	☐
Swollen Ankles	☐	☐	Tuberculosis	☐	☐	ADHD	☐	☐
Anemia	☐	☐	AIDS or HIV Infection	☐	☐	Autism	☐	☐
Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Other	☐	☐
Recent Weight Loss	☐	☐	Herpes Simplex Virus 1	☐	☐			

Please list any specific conditions or information that may pertain to your diagnosis above(example, if diabetic A1C Number):

_____

_____

Patient Dental History

Name of Previous Dentist & Location: _____ Date of Last Exam: _____

Preferred Pharmacy & Location: _____

	Yes	No
1. Are your teeth important to you?	☐	☐
2. Do you feel pain in any of your teeth?	☐	☐
3. Do you clench or grind your teeth?	☐	☐
4. Have you had any head, neck, or jaw injuries?	☐	☐
5. Do you have any swelling in jaw or mouth?	☐	☐
6. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐

What are your overall expectations/goals for your oral health? _____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize the dental provider to reach out to a physician. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date