FRANKLIN PRIMARY HEALTH CENTER INC

PATIENT INFORMATION FORM

NAME		SOCIAL SEC #	ACCT#	
ADDRESS		VETERAN (YES or NO)	EMPLOYER	
ADDRESS		****IN AN EMERGENCY****	RACE (List all that apply)	
CITY/ZIP		EMERGENCY CONTACT NAME	SEX	MARITAL STATUS
HOME	CELL	EMERGENCY CONTACT PHONE	DOB	

RESPONSIBLE PERSON		RELATION
ADDRESS		ACCT#
SOC SEC#	DOB	SEX

INS	PT ID	INS ID	CARRIER	EXPIRARTION
INS	PT ID	INS ID	CARRIER	EXPIRATION
NAME PHARMACY OF CHOICE	PHONE#	ADDRESS		
EMAIL ADDRESS				

HOUSEHOLD INFORMATION: INCOME INCLUDED: GROSS WAGES, SS INCOME, RAILROAD RETIREMENT, UNEMPLOYMENT COMP, STRIKE BENEFITS, WORKER'S COMP, PUBLIC ASSISTANCE, VETERAN'S PAY, CHILD SUPPORT, ALIMONY, INSURANCE OR ANNUITY PAYMENTS, ETC.
WRITTEN DOCUMENTATION FOR ALL SOURCES OF INCOME, FOR ALL HOUSEHOLD MEMBERS MUST BE PROVIDED

NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY

IN ORDER TO ASSIST US IN PROVIDING YOU MEDICAL CARE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. What language do you prefer to use:_____
2. DO YOU HAVE ANY CULTURAL OR RELIGIOUS BELIEFS THAT WOULD INFLUENCE YOUR DECISION TO RECEIVE ANY ASPECTS OF HEALTHCARE SERVICES PROVIDED? _____
3. DO YOU CURRENTLY HAVE ADVANCE DIRECTIVES/LIVING WILL? **YES** ( ) (Provide Copy) **NO** ( )
4. IN CASE OF AN EMERGENCY WHO WOULD YOU LIKE US TO DISCUSS YOUR MEDICAL INFORMATION WITH?

NAME: _____RELATION: _____ NAME: _____ RELATION: _____

FRANKLIN'S PATIENT RIGHTS AND REPSONSIBILITIES, NOTICE OF PRIVACY PRACTICES AND GRIEVANCES POLICIES HAVE BEEN EXPLAINED TO ME AND I HAVE RECEIVED A COPY. I HAVE ALSO BEEN INFORMED THAT IF I HAVE A COMPLAINT OR EXPERIENCE ANY PROBLEMS DURING MY VISIT TO ASK FOR THE OFFICE MANAGER. INITIALS: _____

ASSIGNMENT AND RELEASE: I, THE UNDERSIGNED CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT, I CONSENT TO ANY SERVICES RENDERED TO ME OR MY DEPENDENTS UNDER DOCTOR'S ORDERS. I AUTHORIZE PAYMENT OF HEALTHCARE BENEFITS TO FPHC, INC. I UNDERSTAND THAT I AM FINANCIALLY REPONSIBLE FOR ALL CHARGES AND REFERENCE LAB FEES NOT PAID BY INSURANCE. I HEREBY AUTHORIZE FPHC, INC., TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.

SIGNATURE: _____ DATE: _____

( ) Patient ( ) Parent ( ) Guardian

INTERVIEWER: _____ DATE: _____

Our Mission: To be a compassionate and viable Community Health Center.
Our Vision: To be the provider of choice in the communities we serve.

FRANKLIN PRIMARY HEALTH CENTER INC

SLIDING FEE SCALE SELF-DECLARATION

This is a self-declaration to show your eligibility to receive a sliding fee scale discount on charges incurred as a result or treatment at any location of Franklin Primary Health Center, Inc. All household income must be reported to be considered. Income may be from any one or combination of the following sources:

1. Employment
2. Unemployment Compensation
3. Public Assistance (TANF, etc.)
4. Child Support, Alimony, regular monetary gifts from family or friends.
5. Interest income from savings, checking, Christmas savings
6. U.S. Savings Bonds, stocks or bonds of any kind
7. Pensions, annuities, retirement funds, etc. (This includes benefits you may receive from being a beneficiary of life insurance or retirement)
8. Social Security or disability income.
9. ANY OTHER INCOME (includes tips, property sold, babysitting, etc.)

Please check the following:

- I, _____, nor anyone in my household receives an income from any of the above sources.

- I, _____, or someone in my household receive the following total income from one or more of the above sources.

- Weekly $ _____; Biweekly $_____; Semi Monthly $ _____; Monthly $ _____

- I, _____, do not wish to show proof of my income; I will not be eligible for a sliding scale discount on services received at Franklin Primary Health Center, Inc. I further understand that I am responsible for the full amount of charges and payment in full at the time of each visit.

I do hereby swear and affirm that the above checked statement is true and correct. The process of qualifying for the sliding fee scale discount was explained to me. Should I have additional questions, I have been instructed to consult the intake clerk, the office manager or a clerk in the billing department.

_____ _____

SIGNATURE DATE

:DOB:_____

Chart No.:_____

Franklin Primary Health Center, Inc.

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. Our Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are require by law to give you a copy of our Privacy Notice and to obtain your written acknowledgment that you have received a copy of this notice.

As a courtesy to our patients we are supplying everyone with a copy of the Advance Directives.

Patient Acknowledgement of Receipt

I, _____, hereby acknowledge that I have
(Print)

Received a copy of Franklin Primary Health Center, Inc., Notice of Privacy Practices/Advance Directives Information.

_____

Patient's Signature Date

_____

Signature of Parent or Patient's Representative (if applicable) Date

_____

_____

Description of Legal Authority to Act on Behalf of Patient

FRANKLIN PRIMARY HEALTH CENTER INC

Patient Questionnaire

Name _____ D.O.B _____

What is your race? (Circle one) Black/African American White/Caucasian

Asian Native Hawaiian Other Pacific Islander

American Indian/Alaska Native More Than One Race

Are you Hispanic/Latino? Yes/No

What Sex is listed on your Birth Certificate? Male Female

What is your Sexual Orientation? Straight Lesbian/Gay Bisexual

Something Else Don't Know

What is your Gender Identity? Male Female Transgender Male/Female-to-Male

Transgender Female/Male-to-Female

Women age 21-65- When and where was your last Pap smear? _____

Women age 40 and over- When and where was your last Mammogram? _____

Women and men age 50- When and where was your last Colonoscopy _____

If you have diabetes- When and where was your last Eye exam? _____

When was your last Dental exam- Date _____ Where _____

If you have Diabetes- When and where was your last visit to "Foot Doctor?"

_____

Have you had your Flu shot? Yes or No If so, when _____ Where_____

Women and men age 65 and older- Have you had your pneumonia shot? Yes or No

If so, when _____ Where_____

Are you on Coumadin or another blood thinner?

_____

Other than Franklin providers, are you seeing any other doctors? (Including specialist) If yes, please list them below:

Doctor _____ Reason _____

Date of last visit _____

Doctor _____ Reason _____

Date of last visit_____

Have you been admitted to the hospital and/or visited the ER within the last 3 months? If so, please list details below:

Dates _____

Hospital and/or ER _____

Reason _____

Which Pharmacy do you use?

Name _____

Address _____

Phone _____

FRANKLIN PRIMARY HEALTH CENTER INC

PATIENT SATISFACTION SURVEY

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Your age: ____

Your Sex: Female _____ Male _____

Date: ____

Your Race/Ethnicity: ____ Asian

____ Pacific Islander

____ Black/African American

____ American Indian

____ White (Not Hispanic/Latino)

____ Hispanic or Latino

____ Other, Please List _____

____ Unknown

Franklin Location: _____

Please circle how well you think we are doing in the following areas:						
Ease of Getting care:		**GREAT**	**GOOD**	**OK**	**FAIR**	**POOR**
1	Ability to get an appointment	5	4	3	2	1
2	Hours Center is open	5	4	3	2	1
3	Convenience of Center's location	5	4	3	2	1
4	Prompt return on calls	5	4	3	2	1
Waiting:						
5	Wait time for Provider	5	4	3	2	1
Provider:						
6	Listens to you and takes time with you	5	4	3	2	1
7	Overall care you received from your provider	5	4	3	2	1
Nurse, Medical Staff, & Receptionist:						
8	Respect and courtesy of our staff	5	4	3	2	1
Payment:						
9	The charges of what you paid were explained	5	4	3	2	1
10	Collection or payment/money	5	4	3	2	1

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Facility:						
11	Cleanliness and Appearance of facility	5	4	3	2	1
Confidentiality:						
12	Keeping my personal information private	5	4	3	2	1

(Turn over)

Access, Comprehensiveness, Coordination And Continuity Of Care:						
13	Overall, how would you describe your EXPERIENCE and SATISFACTION of getting care you need, medication, services and understanding?	5	4	3	2	1
14	How well are we doing to make sure you get ALL the care, medication and services you need WHEN YOU NEED IT?	5	4	3	2	1
15	LIKELIHOOD of recommending our practice to family/friends?	5	4	3	2	1

Please Check Yes or No.

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Do you consider this center a regular source of care?

- ○ Yes
- ○ No

If you would like to be contacted regarding your recent visit,
go to https://franklinprimary.org/contact-us/

Please let us know if you would like to recognize an outstanding employee or if there is anything we could have done better.

_____

_____

_____

_____.

Thank you for completing this survey!

Your feedback is extremely valuable to us as it helps us to understand how we can serve you best.

FRANKLIN PRIMARY HEALTH CENTER INC

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

As a patient of Franklin Primary Health Center, Inc., you have the following rights:

- To be treated with respect, consideration and dignity and to received high quality health care.
- To not be discriminated against in the delivery of health care services.
- To be assured of confidential treatment and to authorize the release of identifiable health care and other personal information.
- To review and have copies of your medical records and to request your record be amended.
- To choose your health care provider.
- To be informed of your medical condition, treatment plan, and expected outcome and to give informed consent prior to treatment except in an emergency.
- To receive accurate, easily understood information and to request assistance or be represented by parents, guardians, family members, or others making informed health care decisions.
- To refuse treatment and refuse to participate in research.
- To be informed of the names, functions, and credentials of all persons providing service to you and to receive the names and telephone numbers of management.
- To be informed of services available, hours of service and after-hours coverage.
- To have fair and efficient process for voicing grievances and recommending changes to management.

As a patient of Franklin Primary Health Center, Inc., you have the following responsibilities:

- To give truthful and accurate information about your health and past medical treatment.
- To ensure that you fully understand and follow the treatment plan prescribed by your health care provider.
- To inform your health care provider of any changes in your condition or of any adverse reactions to the treatment plan.
- To keep appointments and inform the center in advance when you are unable to keep an appointment.
- To pay for services rendered in accordance with the fee policy and to provide truthful and accurate financial and/or insurance information to allow for appropriate billing.
- To become informed of and to follow health center rules and regulations concerning patient care and conduct.

SUBMIT

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