Northland Health Centers
416 Kundert Street
Turtle Lake, ND 58575
701-448-9225

Today's Date: NHC staff initials:

Patient Information Form

Legal Name (First, Middle, Last)		***Name used*** (if different)	
Date of birth	***Sex at birth*** (Male or Female)	***Social Security Number***	
Occupation:		***Employer name and number:***	
Mailing Address		***City***	***State*** ***Zip***
Physical Address (if different)		***City***	***State*** ***Zip***
Email address		***Best way to receive reminders?*** (circle one) Phone Text Email	
Primary Care Physician's name		***PCP's phone number***	***Your Pharmacy***
Cell phone Leave voicemail? Yes No	***Home phone*** Leave voicemail? Yes No	***Work phone*** Leave voicemail? Yes No	***How may we contact you?*** Cell Home Work Email

If you are not available, may we speak to anyone else? Please circle: No or Yes (list all below)

Emergency Contact's Name	***Their phone number***	***Their relationship to you***
Can we tell this person you're due for a test/appointment? Y or N Can we give them details about dates and or/preparations for a test or appointment? Y or N Can we discuss your test results, conditions, and/or medical care? Y or N?		
Other Contact's Name	***Their phone number***	***Their relationship to you***
Can we tell this person you're due for a test/appointment? Y or N Can we give them details about dates and or/preparations for a test or appointment? Y or N Can we discuss your test results, conditions, and/or medical care? Y or N?		

How did you hear about our clinic?

☐ Billboard	☐ Patient referral	☐ Provider referral	☐ Event:_____
☐ Insurance referral	☐ Already a patient here	☐ Yellow pages	☐ Other:_____
☐ Radio/TV	☐ Web search	☐ Phone book	
☐ Direct mailing	☐ Facebook	☐ Noticed building/sign	

Guarantor/Responsible Party Information- skip if patient is 18+ and responsible for self

Full Legal Name *of Person or Entity responsible for paying the final balance of the account*		
Patient relationship to Guarantor- *the patient is (circle one):* Child Foster Child Spouse/Partner Self (skip to Additional Patient Data) Other:		
Date of Birth	***Social Security Number***	***Sex***
Mailing address	***City, State, Zip***	***Cell Phone***
Home Phone	***Work Phone***	***Employer***

Consents and Acknowledgements

Authorization for Treatment- *initial in boxes*

☐ I authorize Northland Health Centers (NHC) to do exams, treatments, lab tests, radiographs, and to provide me medications that the provider thinks I or _____need(s) to stay healthy.
☐ I know that I will be told the reason for the treatment/procedure(s), the benefits or risks with it, and other treatment options.
☐ I know that there are risks with the treatment/procedure(s) and the community health center cannot promise success.

Patient Rights and Responsibilities- *initial in boxes*

☐ I acknowledge and agree that I received a copy of my **Patient Rights and Responsibilities**. I agree that I fully understand my rights and responsibilities as a patient and that if I neglect to fulfill them I may be terminated as a patient of NHC.
☐ I acknowledge that I have received NHC's **Patient Financial Responsibility Notice**. I understand that I may ask questions about the Patient Financial Responsibility Notice at any time. I agree that I fully understand my financial responsibilities as a patient and that if I neglect to fulfill them, I may be terminated as a patient of NHC.
☐ I hereby acknowledge and understand my responsibilities as a patient, and authorize NHC to release all information necessary to secure the payment and benefits from my insurance carrier to my provider and from the insurance company to NHC when needed. I have read the above and understand that I am responsible for payment of my account.

HIPAA and Privacy Practices- *initial in boxes*

☐ I acknowledge that I have received NHC's **Notice of Privacy Practices**. I understand that I may ask questions about the Notice of Privacy Practices at any time.
☐ I acknowledge the following statement: NHC Providers and Counselors make every possible effort to protect your confidentiality. There are however limits to confidentiality. NHC Providers/Counselors, as required by law, are mandatory reporters of child abuse and neglect and are also required to report abuse and neglect of vulnerable adults. In such cases a report is filed with county social services. In situations where a client states suicidal or homicidal intention, our Counselors by law have a duty to warn and are to make sure the client and/or threatened person/s are safe. This may require the Counselor to call an emergency contact or emergency services, and in cases of threat of harm to others, warn the person who has been threatened.
☐ I acknowledge the following statement: NHC does not permit audio or video recording of any client care sessions with your Medical, Dental, or Mental Health Provider. If you would desire a record of information from your session, you will be provided with a written copy of the information or instructions given during your medical, dental, or mental health session by your Provider.

Sliding Fee Scale Discount Program- *initial in boxes*

☐ I understand that NHC is a Federally Qualified Health Center (FQHC). I also understand that because NHC is an FQHC, all patients are eligible to apply for the Sliding Fee Scale discount program, entitling patients to discounted medical, behavioral health, and dental care based on household size and income.
☐ I acknowledge that clinic staff has educated me about the Sliding Fee Program and allowed me to ask questions regarding the program. I have been offered an application.

- ☐ At this time, I am choosing to **apply** for the program and will provide the completed application and all required income verification documents within 30 days from today's date.
- ☐ At this time, I am choosing **not to apply** for the Sliding Fee Scale program. I understand that I am able to apply at any time by contacting clinic staff or the Administrative offices.

By signing below, I acknowledge that I have read and understand the above statements.

_____ _____
Patient (or guardian) Signature Date

Additional Patient Data

This information is for demographic reporting purposes only and will not affect your care. We use this information to apply for grants and other financial assistance, and to ensure that we're providing the best care to all of our patients. If you do not wish to answer any of these questions, please leave them blank. If you have any questions, please speak with an NHC staff member.

Living arrangement:

- ☐ *Permanent Residence*- own or rent an apartment, room, house, etc.
- ☐ *Doubling Up*- living with other people for a temporary period and moving often
- ☐ *Transitional*- center, community home
- ☐ *Homeless Shelter*- safe havens, temporary overnight housing, armories
- ☐ *Street*- sidewalk, car, park, doorway, public or abandoned building, etc.
- ☐ *Other*- hotel, motel, day-to-day single room occupancy, etc:

Are you worried about losing your housing?

☐ yes ☐ no ☐ maybe:_____

Race (check all that apply):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ White or Caucasian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Unknown
- ☐ Other:

Ethnicity:

☐ Hispanic ☐ not Hispanic

Do you think of yourself as:

- ☐ Straight ☐ Bisexual
- ☐ Gay or Lesbian ☐ Don't know
- ☐ Something else:

What is your current gender?

- ☐ Male ☐ Transgender- M to F
- ☐ Female ☐ Transgender- F to M
- ☐ Other:

What are your pronouns?

- ☐ He/his ☐ They/theirs
- ☐ She/hers ☐ Other:

What is your legal sex?

☐ Male ☐ Female

Country of birth:

☐ USA ☐ Other:_____

Relationship status:

- ☐ Single ☐ Married
- ☐ Divorced ☐ Partnered
- ☐ Separated ☐ Widowed
- ☐ Other:

What language are you most comfortable speaking?

☐ English ☐ Other:_____

Have you been discharged from the armed forces of the USA?

☐ Yes ☐ No

What is your current work situation?

- ☐ Employed full time ☐ Student full time
- ☐ Employed part time ☐ Student part time
- ☐ Employed temporarily
- ☐ Unemployed, seeking work
- ☐ Unemployed, not seeking work (retired, disabled, unpaid primary caregiver, etc.)
- ☐ Other:

How many jobs do you currently have? _____

How many hours per week do you work?_____

At any point in the last 2 years, has seasonal or migrant farm work been your or your family's main source of income? If you are a resident of North Dakota who farms or ranches for your income, check no.

☐ Yes ☐ No

What is the highest level of school you have completed?

- ☐ Less than high school diploma
- ☐ More than high school diploma
- ☐ High school diploma or GED
- ☐ Unknown

Additional Patient Data

This information is for demographic reporting purposes only and will not affect your care. We use this information to apply for grants and other financial assistance, and to ensure that we're providing the best care to all of our patients. If you do not wish to answer any of these questions, please leave them blank. If you have any questions, please speak with an NHC staff member.

A household is defined as all people living together who are financially dependent upon each other. Answering these questions will help up determine if you are eligible for discounts on your healthcare services or any other benefits.

How many people, including yourself, are currently living in your household? _____

What is the combined annual income of everyone living in your household? _____

What is your main insurance?

☐	None/uninsured	☐	Medicaid
☐	Medicare	☐	Phone
☐	Other:		

Within the past 12 months, have you or any member of your household been unable to get any of the following when it was really needed (check all that apply)***:***

☐	Utilities	☐	Clothing
☐	Childcare	☐	Medicaid expansion
☐	Medicine or any healthcare services (medical, dental, counseling, vision, prescriptions, etc.)		
☐	Other:		

Within the past 12 months, you were worried whether your food would run out before you got money to buy more.

☐ Always true ☐ Sometimes true ☐ Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

☐ Always true ☐ Sometimes true ☐ Never true

Would you like to be contacted to talk about resources that might be helpful to you?

☐ Yes ☐ No

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply:

☐	Yes, it has kept me from medical appointments or from getting my medications.
☐	Yes, it has kept me from non-medical appointments, work, or from other things that I need.
☐	No
☐	Other:

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled.

☐	Not at all	☐	A little bit
☐	Somewhat	☐	Quite a bit
☐	Very much	☐	Other:

How often do you see or talk to people that you care about and feel close to? For example- talking to friends or family on the phone, visiting friends or family, going to church, club meetings, or other social events and activities.

☐	Less than once a week	☐	1 or 2 times a week
☐	3 to 5 times a week	☐	5+ times a week

In the past 12 months, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

☐ Yes ☐ No

Are you a refugee?

☐ Yes ☐ No

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No

In the past 12 months, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No