Patient Name: ____**Acct. No:** ______________________

Date of Birth:_______________________ **Sex**: □ Male □ Female □ Transgender □ Other

Address: ____City, State, & Zip:______________________________

Communication: I authorize Vibrant Health to reach me via □ Mail □ Phone Calls □ Email □ Text Message

Email Address:____

Please check if you would like to opt out of receiving text messages: □ Yes □ No
(Vibrant Health is not responsible for carrier charges for text messages)

Home Phone: ______________________ **Cell Phone**: _____________________ **Work Number**: ____________________

How did you hear about us? ____

Race:

□ American Indian/Alaska Native □ Asian □ Black/African American

□ More than one race □ Native Hawaiian □ Other Pacific Islander

□ Other race □Unreported/Refused to report □ White

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Refused to Report

Employer's Name:_______________________________ **Employer's Address**:___________________________________

Emergency Contact:____**Contact's Phone#**: _________________________

Relationship:_____________________________ Is it okay to communicate with this person? □ Yes □ No

Responsible Party for Billing: □ Self □ Spouse □ Parent □ Other ____

Name (if not Self): ____

Address: ____Phone Number: ________________________

Pharmacy Name:_______________________________ **Pharmacy Address**: __________________________________

<u>Insurance Information</u>

Primary Insurance____

Subscriber Name: ____ Date of Birth: ____________________

Subscriber ID: ______________________________________ Subscriber Group Number: _________________________

<u>List all source of income in your home</u>

Total monthly income of ENTIRE household from all sources before taxes: $_____________________

Total number of people in the household: _______

Please list the full name and date of birth of household members who are patients:-

____

____

____

Migrant Farmworker: Have you or anyone in your family worked in agriculture? For example: planting, picking, preparing soil, packing house, driving a truck for any type of farm work, worked with animals like cows or chickens, etc.
□ Yes □ No

This information is true and correct to the best of my knowledge.

Print Name: ___________________________________Sign: _______________________________ Date:____________

(1) Consent for Treatment

I consent to have Vibrant Health provide myself and or my child(ren) the medical, dental and or behavioral health care that the doctor or his/her health care staff recommend. Unless it is an emergency, they will describe this medical care and any significant risks to me before treatment.

PROTECTED HEALTH INFORMATION The undersigned acknowledges receipt of the Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. I hereby authorize the verbal release of my Protected Health Information for discussion of my care, treatment, and/or payment to the person(s) specified below. (45CFR 164.502(F) & 164.502 (G))

Please list any other parties who can have access to your health information:

____

Name Relationship Phone

(2) Paying for Treatment

I agree that Vibrant Health will bill my insurance plan for the care I receive. I understand that Vibrant Health can bill me in any of these cases:

(a) When I do not have insurance coverage
(b) When my insurance plan does not cover the treatment
(c) When I owe a deductible or there is a balance left after my insurance pays
(d) When I choose not to use my health plan and agree to pay for my care myself

I know that I must pay for any co-payment or other part of the bill that my insurance plan says I must pay. I know that I am expected to pay before treatment in most cases.

Our Responsibilities We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. **Changes to this notice:** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

I authorize Vibrant Health, through its medical software eClinicalworks, to download my prescription history for the purpose of complete/continued treatment.

I have reviewed this consent form and give my permission to Vibrant Health to use and disclose the patient's health information in accordance with it. I am signing this document as an annual acknowledgement of the opportunity to read through the complete HIPAA polices of Vibrant Health.

PATIENT NAME:

_________________________________ _______________________________ _________________

Print Guarantor Name Sign Date