228 Lafayette Street
332 South 8th Street
491 Clinton Avenue
Newark, New Jersey 07105
Telephone (973) 789-8111

Saint James Health
A Federally Qualified Health Center

PATIENT INFORMATION FORM

PLEASE PRESENT YOUR CURRENT INSURANCE CARD AND ID FOR PHOTOCOPYING

GENERAL INFORMATION

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

Social Security # _____ **Date of Birth:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:**_____ **Birth Sex:** ___ Female ___ Male ___Unknown

Home #: _____ **Cell #:**_____

Email: _____ **Primary Language:**_____

Patient Sexual Orientation:
☐ Straight ☐ Lesbian or Gay ☐ Bisexual
☐ Something Else ☐ Don't Know
☐ Choose Not To Disclose

Gender Identity: ☐ Male ☐ Female
☐ Transgender: Male/Female-to-Male
☐ Transgender: Female/Male-to-Female
☐ Choose Not To Disclose ☐ Other

Race: (Mark All That Apply)
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ African American/Black
☐ American Indian/Alaska Native ☐ European/White ☐ Unreported/Refuse To Report

Ethnicity: Hispanic or Latino? ☐ Yes ☐ No ☐ Unreported/Refuse To Report

Emergency Contact: (To Be Contacted **Only** In The Event Of An Emergency)
Name: _____ **Phone:** _____ **Relationship:** _____ 18 or over ☐ Yes ☐ No
Name: _____ **Phone:** _____ **Relationship:** _____ 18 or over ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you lack permanent housing (Are you experiencing Homelessness)? ☐ Yes ☐ No
If yes, check one: ☐ Doubling Up (Living with Friends or Family) ☐ Homeless Shelter ☐ Street
☐ Transitional ☐ Unknown (Decline To State) ☐ Unknown

Approximate Monthly Household Income?
☐ Under $1,000 ☐ $1,000 - $1,500 ☐ $1,500 - $2,000 ☐ $2,000 – 2,500 ☐ $2,500 - $3,000
☐ $3000 - $3,500 ☐ $3,500 - $4,000 ☐ $4,000 - $4,500 ☐ $4,500 – 5,000 ☐ $5,000 - $5,500
☐ $5,500 - $6,000 ☐ Over $6,000

How many people live in your Home? _____

Patient Name: _____ **Date of Birth:** _____

PRIMARY INSURANCE

Insurance Company: _____ **Member ID:** _____ **Group ID:** _____

Relationship to Insured: ___ **Self** ___ **Spouse** ___ **Child** ___ **Other:** _____

Name of Policy Holder: _____ **Policy Holder Date of Birth:** _____

Policy Holder Address: _____

SECONDARY INSURANCE

Insurance Company: _____ **Member ID:** _____ **Group ID:** _____

Relationship to Insured: ___ **Self** ___ **Spouse** ___ **Child** ___ **Other:** _____

Name of Policy Holder: _____ **Policy Holder Date of Birth:**_____

Policy Holder Address: _____

Pharmacy Name: _____ **Pharmacy Phone #:** _____

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Privacy Information And Consent Form

Privacy and Security. April 14, 2003 the Federal Government implemented the Health Insurance Portability and Accountability Act ("**HIPAA**") which provides safeguards to protect you and/or members of your family's privacy. Saint James Health ("**SJH**") has adopted policies and implemented procedures to protect you and your family's privacy rights.

Electronic Medical Record ("EMR"). In conducting our business, we will create electronic medical records ("**EMR**") regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your health information. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time of service.

Protected Health Information. **SJH** follows federal and state guidelines, rules, and restrictions on who may see or be notified of your Protected Health Information ("**PHI**") and/or electronic Protected Health Information ("**ePHI**"). **HIPAA** provides certain rights and protections to you as the patient. **SJH** participates in health information exchanges ("**HIEs**") to make patient information available electronically to participating hospitals, doctors, and other healthcare providers. **SJH** may also receive information about you/minor from other Providers in the **HIE** network. Additional information is available from the U.S. Department of Health and Human Services ("**HHS**") at www.hhs.gov.

Consent for Treatment. I authorize **SJH** and its Provider staff to provide such health care services and administer diagnostic and therapeutic procedures and treatments as, in the judgment of **SJH's** Providers, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination.

Release of PHI/ePHI Information. I authorize **SJH** to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable **SJH** to obtain payment for the services; and (3) to permit **SJH** to carry out ordinary health care and business operations.

Assignment of Benefits. I assign to **SJH** all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and any other third parties who are financially liable for the medical care and treatment provided by **SJH**.

Financial Obligations. **SJH's** schedule of fees for the provision of services is designed to cover reasonable costs and is consistent with local prevailing rates and/or charges. **SJH** will apply a Sliding Fee Discount Schedule ("**SFDS**"), so that the amounts owed for **SJH** services by eligible patients are adjusted based on income and family size.

I agree I am responsible for any applicable copayments, coinsurance or deductibles, except as may be limited by federal regulation or by the **SJH** published Sliding Fee Discount Schedule ("**SFDS**").

I certify that I have read this form and that I am the patient, or I am authorized as the patient's representative to execute this form and accept its terms.

Print Name of Patient: _____

Patient or Responsible Party Signature: _____

Nature of Relationship to Patient (If Patient Not Signing): _____

Date: _____

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PHARMACY TRANSFER FORM

☐ Yes, I would like to change my pharmacy to **APOVIA PHARMACY SERVICES**, which has 340B discounts for Saint James Health patients and home delivery.

☐ No, please use my current Pharmacy _____.

Name: _____ **D.O.B.** _____

Patient Phone Number: _____

Patient Address:

_____

_____

_____

Insurance: _____ **ID#** _____

BIN: _____ **PCN:** _____ **Group:** _____

Allergies: _____

Primary Doctor: _____

I am rendering my information willingly to Apovia Pharmacy Services, 313 Henderson Drive, Sharon Hill, Pennsylvania 19079.

Signature: _____

Date: _____

Saint James Health Front Desk Fax To: (855) 540-2413