HealthWorks
Where health happens

Patient Preferred Name: **Pronoun(s):**	**Name of School (if applicable):** **Applying for Sliding Fee Scale: Y or N**				**Primary Care Provider (PCP): _____** Send results: Yes or No Notify upon Admit/Discharge: Yes or No	
Legal Last Name	**First Name, Middle Initial**	**Former/Maiden Name(s)**	**Birth Date**	**Gender Identity** M F	**Sex** **M F**	**Social Security #**
Physical Address	**City**	**State**	**Zip Code**	**County**	**Home Phone (if applicable)**	
Mailing Address/P.O. Box	**City**	**State**	**Zip Code**	**County**	**Cell Phone**	
Message Phone	**Email Address**	**Would you like to enroll into MyChart? (circle one)** **Yes No Currently Enrolled**		**Marital Status (check one)** ☐ Single ☐Married ☐Partner ☐Significant Other ☐ Legally Separated ☐Divorced ☐Widowed ☐Minor Child ☐Other ☐Unknown		
Race (check all that apply) ☐African American ☐Multiracial ☐ White/Caucasian ☐ American Indian/Alaska Native ☐Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Other ☐Decline to answer ☐ Unavailable		**Ethnicity (check one)** ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Decline to answer ☐ Unavailable		**Housing Information (check one)** ☐Own ☐Rent ☐Rent Free ☐HUD/CHA ☐Shelter ☐Group Home ☐Transitional ☐Doubling Up ☐Homeless-street/car If homeless, how long? _____		
Are you a Veteran? ☐No ☐non-Combat ☐Combat	**Patient place of birth (State)**	**Employment (check one):** ☐Full Time ☐Part Time ☐Self Employed ☐Not Employed ☐Disabled ☐Retired ☐Homemaker ☐Active Military Duty ☐Student -Full Time ☐Student-Part Time ☐Minor		**Employer Name and Address**		
				Employer Phone	**Date Hired**	
Can someone claim you as a dependent? Yes or No **If yes, provide the name of the person who claims you on their taxes.** _____	**Financial Household Size (from your tax return or legal documentation)** _____	**Type of Income/Gross Monthly Income** ☐**Check here if No income** ☐ Wages $_____ ☐Self-Employment $_____ ☐Worker's Comp $_____ ☐Unemployment $_____ ☐Social Security/SSI $_____ ☐Military/VA Benefits $_____ ☐Pension/Retirement $ _____ ☐Trust Fund Monies $_____ ☐Alimony $_____ ☐Rental Income $_____ ☐Other _____ $_____		**Estimated Annual Income:If you are insured OR self-pay and <u>DECLINING</u> our sliding fee scale program, please provide your estimated income: $_____**		

How did you hear about us?
☐Existing Patient ☐Referral from another provider ☐Referral from family/friend ☐Neighbor ☐Advertisement ☐AM/FM Radio ☐Billboard ☐Local news Channel
☐Social Media ☐Magazine Ad ☐Newspaper Article ☐Staff ☐TV Commercial ☐ Other: _____

Responsible Party Information: **COMPLETE ONLY IF RESPONSIBLE PARTY IS DIFFERENT FROM THE PATIENT LISTED ABOVE.**
The responsible party is financially responsible for the services received during the health care visit with HealthWorks. In some instances, this person may not be the same individual legally able to provide consent for treatment. For questions or concerns, please speak with the front office staff, 307-635-3618 (option 1).

Name of Responsible Party	**Relationship to Patient (circle one)** Mother Father Legal Guardian Other:_____	**Sex** M F	**Date of Birth**	**Social Security #**	**Home Phone: _____** **Work Phone: _____**
Mailing Address (if different from patient)	**Name and Address of Employer**	**Employment (check one):** ☐Full Time ☐Part Time ☐Self Employed ☐Not Employed ☐Disabled ☐Retired ☐Homemaker ☐Active Military Duty ☐Student -Full Time ☐Student-Part Time ☐Minor			**List this Party as an Emergency Contact:** **Yes or No**

Other Emergency Contact(s): Please list any additional individuals you would like contacted in case of an emergency if the primary contact on file is not available.

Name	**Relationship to Patient (circle one)** Mother Father Legal Guardian Other:_____	**Sex** M F	**Date of Birth**	**Cell Phone:** _____ **Work Phone:** _____	**Mailing Address (if different from patient)**
Name	**Relationship to Patient (circle one)** Mother Father Legal Guardian Other:_____	**Sex** M F	**Date of Birth**	**Cell Phone:** _____ **Work Phone:** _____	**Mailing Address (if different from patient)**

PATIENT INSURANCE INFORMATION

Health Insurance? ☐Yes ☐No	Medicare if yes please include policy # ☐Yes ☐No	Equality Care/Medicaid if yes please include policy # ☐Yes ☐No	Kid Care if yes please include policy # ☐Yes ☐No	Prescription Coverage ☐Yes ☐No
Prescription coverage from Prescription Drug Assistance Program (PDAP)? ☐Yes ☐No		Medicare Part D ☐Yes ☐No	If unemployed, are you eligible for COBRA benefits? ☐Yes ☐No	

Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder ___/___/___	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (____) _____-_____	Employer:	Employer phone: (____) ____-_____

Secondary Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder ___/___/___	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (____) _____-_____	Employer:	Employer phone: (____) ____-_____

Are you seeking medical care because of an accident? ☐Yes ☐No If yes, answer following questions…

Date of accident: / /	Was it a motor vehicle accident? ☐Yes ☐No	Was the accident work related? ☐Yes ☐No	Where did the accident occur?
Workers Compensation number:	If motor vehicle accident, name of auto insurance company and policy number:		Do you have an attorney involved and/or a settlement pending? ☐Yes ☐No

ASSIGNMENT AND RELEASE: I authorize HealthWorks to disclose medical information as necessary to receive payment and assign all benefits, if any, directly to HealthWorks that otherwise might be payable to me for services rendered. I understand HealthWorks may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months. If I choose to seek medical care with another provider, I understand that the treatment and information may still be shared with my insurance or another medical carrier. I understand that HealthWorks will file an initial claim with Medicare, Medicaid, or any other third-party insurance, if I have provided and signed the necessary information and/or forms. I understand that I am financially responsible for all my charges whether they are covered by my insurance carrier. I also agree to be responsible for payment of any services rendered if my insurance company takes longer than sixty (60) days from date of service. If this occurs, I will be responsible for seeking reimbursement from my insurance company. I authorize the use of this signature on all insurance submissions

Signature of Responsible Party: _____ **Print Patient Name: _____**

Relationship to Patient: _____ **Date: _____**

WYOMING IMMUNIZATION REGISTRY

I understand that the state of Wyoming maintains an immunization registry. The benefits of the registry are to prevent duplication of immunizations, provide timely notification of immunizations due, and to serve as a backup in case you lose your record of vaccination(s). Immunization records are only accessible by authorized health care providers, and schools.

☐ I authorize HealthWorks to enter information regarding my (or my child's) immunizations into the Wyoming Immunization Registry.
☐ I choose to no longer have myself (or my child) participate in the Wyoming Immunization Registry and request that my (or my child's) immunizations be removed from the Wyoming Immunization Registry.

Patient's Name: _____ **Date:** _____

Authorized Signature: _____ **Relationship to Patient:** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

HealthWorks is committed to protecting the confidentiality of your medical information and is required by law to do so. The Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information to carry out treatment, payment, health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. By subscribing my name below, I acknowledge that I was provided a copy of the NPP and that I have read (or had the opportunity to read if I so choose) and understand the NPP and agree to its terms.

Patient or Authorized Signature_____**Date**_____

HEALTH AND MEDICAL CARE CONSENT

Health and Medical Care Consent: I voluntarily consent to and authorize Cheyenne Health and Wellness Center, its employees, agents and affiliates, to provide such medical care (including evaluation, diagnostic procedures, and medical treatment) as may be deemed necessary and appropriate by my physician, his/her designees. CHWC periodically conducts training programs for health care professionals. These persons may be observing or participating in CHWC's treatment programs. They will be under the direction of supervised licensed professionals. I understand that I have the right to refuse to have trainers or students participate in my care.

Patient or Authorized Signature_____**Date**_____

HealthWorks

Student Name: _____Student DOB:_____Parent/Guardian Name: _____

Student's Current School Name:_____

I, the Student (if over 18 year of age, or otherwise permitted to consent under Wyoming law) or the Parent/Guardian named above, hereby consent for the Student named above, to receive the health care services described below and provided by the licensed health professionals at the school-based health clinic owned and operated by Cheyenne Health and Wellness Center d/b/a HealthWorks, a Wyoming non-profit corporation, as part of the school-based health clinic program approved by Laramie County School District No. 1 ("LCSD1"). I understand that the school-based health clinic (the "SBHC") will ensure confidentiality in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. Services covered by this Consent to Treatment ("Covered Services") may include, but are not limited to:

1. School health services, including screening for vision, hearing, asthma, obesity, and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, college, daycare, sports, employment, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical diagnostic imaging, including x-ray services.
5. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
6. Mental health services including evaluation, diagnosis, treatment, and referrals.
7. Reproductive health care services, including abstinence counseling, providing access to birth control, pregnancy testing, STD screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate.
8. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and tobacco use; age-appropriate education on abstinence, pregnancy prevention, sexually transmitted infections, and HIV.
9. Dental treatment consisting of examinations, x-rays, diagnosis & treatment modalities that may include cleaning, administration of topical and local anesthesia, fillings, and sealants.
10. Referrals for services not provided at the SBHC.
11. Annual health questionnaire/survey.

I agree that the SBHC's health care providers may disclose the Student's protected health information (PHI) to the school's nurse, counselor, or other health care providers for treatment purposes without further authorization, or for those purposes legally permitted without further authorization under Wyoming or federal law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and as otherwise required by law.

I have read and understand the Covered Services and my signature provides consent for the Student to receive the Covered Services as long as the Student is a student at an LCSD1 school. I further agree that I will promptly inform the SBHC in writing of any changes in the Student's physical, mental or dental health and any change in the custody of the Student which affects my ability to provide this consent on behalf of Student.

Parent/Guardian Signature: _____Date: _____

Student Signature: _____Date: _____

Resource and Public Benefit Screening

HealthWorks provides wrap-around services to meet the needs of patients. These services may include referrals, education and enrollment assistance into services that may be of benefit to you and your household. We request that all new patients and/or patients completing annual paperwork answer the following questions below to assist us in serving you. After review, a member of our staff will contact you.

Family and Home

1. What is your housing situation today?
   - ☐ I have housing.
   - ☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on a street, in a car, or in a park).
   - ☐ I choose not to answer this question.
2. If you have housing, in the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
   - ☐ Yes ☐ No ☐ I choose not to answer this question.

Money and Resources

3. In the past year, have you or any family members you live with been **UNABLE** to get any of the following when it was **really needed**? **Mark all that apply.**

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Childcare
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
	I choose not to answer this question.				

4. Does everyone in your household have health insurance? Yes or No
5. In the past 12 months, has lack of transportation kept you from medical appointments or getting medications? ☐ Yes ☐ No
6. In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living? ☐ Yes ☐ No

Social and Emotional Health

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

	Less than once a week		1 or 2 times a week
	3 to 5 times a week		5 or more times a week
	I choose not to answer this question.		

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

	Not at all		A little bit
	Somewhat		Quite a bit
	Very Much		I choose not to answer this question.

Optional Additional Questions

9. Are you a refugee? ☐ Yes ☐ No
10. Do you feel physically and emotionally safe where you currently live? ☐Yes ☐No
11. In the past year, have you been afraid of your partner, ex-partner, boyfriend, girlfriend, parent, or other family member? ☐Yes ☐No

SLIDING FEE SCALE APPLICATION

HealthWorks offers cost assistance to patients who meet income guidelines of 200% of the Federal Poverty Level. See you qualify for additional discounts if your income is **equal to or less than the income below:**

Financial Household Size	Total/Gross Monthly Income (before any deductions)	Total/Gross Annual Income (before any deductions)
1	$2265	$27,180
2	$3051.67	$36,620
3	$3838.33	$46,060
4	$4625	$55,500
5	$5411.67	$64,940
6	$6198.33	$74,380
7	$6985	$83,820
8	$7771.67	$93260

If you would like to apply for our sliding fee scale, please complete the following pages and provide the supporting documents so that we may determine your eligibility.

Additional Financial Household Members

Tell us about each additional member of your Financial Household. Please list every household member claimed on your tax return and use additional pages if needed.

Household Member (relationship to applicant)		Insurance Coverage?	Type of Income for Household Member Gross Total Income Per Month (income before taxes and deductions are taken out)
☐Spouse ☐Child ☐Stepchild ☐Sibling ☐Parent ☐Stepparent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/___ **SSN:** _____-_____-_____ Is this person included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Trust Fund Monies $ _____ ☐Self-Employment $ _____ ☐Alimony $ _____ ☐Worker's Comp $ _____ ☐Rental Income $ _____ ☐Unemployment $ _____ ☐Investments $ _____ ☐Social Security/SSI $ _____ ☐Other $ _____ ☐Military/VA Benefits $ _____ ☐No income ☐Pension/Retirement $ _____
☐Spouse ☐Child ☐Stepchild ☐Sibling ☐Parent ☐Stepparent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/___ **SSN:** _____-_____-_____ Is this person included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Trust Fund Monies $ _____ ☐Self-Employment $ _____ ☐Alimony $ _____ ☐Worker's Comp $ _____ ☐Child Support $ _____ ☐Unemployment $ _____ ☐Rental Income $ _____ ☐Social Security/SSI $ _____ ☐Investments $ _____ ☐Military/VA Benefits $ _____ ☐Other $ _____ ☐Pension/ Retirement $ _____ ☐No income
☐Spouse ☐Child ☐Stepchild ☐Sibling ☐Parent ☐Stepparent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/___ **SSN:** _____-_____-_____ Is this person included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Trust Fund Monies $ _____ ☐Self-Employment $ _____ ☐Alimony $ _____ ☐Worker's Comp $ _____ ☐Child Support $ _____ ☐Unemployment $ _____ ☐Rental Income $ _____ ☐Social Security/SSI $ _____ ☐Investments $ _____ ☐Military/VA Benefits $ _____ ☐Other $ _____ ☐Pension/ Retirement $ _____ ☐No income

Members of household continued:

Please list every household member claimed on your tax return. (**Please use additional pages if needed.**)

Household Member (relationship to applicant		Insurance Coverage?	Type of Income for Household Member Gross Total Income Per Month (income before taxes and deductions are taken out)			
☐Spouse ☐Child ☐Stepchild ☐Sibling ☐Parent ☐Stepparent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/__ **SSN:** _____-____-_____ Is this person included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/ Retirement $ _____		☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other $ _____ ☐No income	
☐Spouse ☐Child ☐Stepchild ☐Sibling ☐Parent ☐Stepparent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/__ **SSN:** _____-____-_____ Is this person included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/ Retirement $ _____		☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other $ _____ ☐No income	

My signature indicates that all the information I have provided is true and correct. I hereby grant permission to this agency to obtain and share the information I have provided for determining eligibility for assistance.

Signature of Responsible Party: _____ **Print Patient Name: _____**

Relationship to Patient: _____ **Date: _____**