AG WORKER HEALTH & SERVICES

Patient Intake Form

Date:_____

First Name_____ **MI**_____ **Last Name**_____
DOB_____ **Preferred Name**: _____ **Sex:** Male - Female

Head of Household: -Self -**First Name**_____ **Last Name** _____
DOB_____ **Sex:** M/F **Phone Number**: _____

Household Members and Dependents: -N/A - : **Total # of Members in Household**:_____
Name: _____ **Sex**: M/F **DOB**: _____ **Relation to you**: _____
Name: _____ **Sex**: M/F **DOB**: _____ **Relation to you**: _____
Name: _____ **Sex**: M/F **DOB**: _____ **Relation to you**: _____
Name: _____ **Sex**: M/F **DOB**: _____ **Relation to you**: _____
Name: _____ **Sex**: M/F **DOB**: _____ **Relation to you**: _____
Name: _____ **Sex**: M/F **DOB**: _____ **Relation to you**: _____

Physical Address: _____ **Apt #**_____**City** _____**State** _____ **Zip Code** _____
Mailing Address: _____**City** _____**State** _____ **Zip Code** _____
Phone Number: **Home/Cell?**_____ **Email**: _____
May We Leave a Message? Yes No **Do you Prefer to be called or texted?** Call Text Both

Preferred Language: English - Spanish- Other: _____ **Interpreter Needed?** Yes / No
Are you a veteran? Yes / No **Do you have a disability?** Yes / No
Marital Status: Single - Married - Partner - Widowed - Divorced- Decline to answer
Race: White - More Than One -Asian - Black/African American - Native American - Native Hawaiian or Pacific Islander - Other_____ - Decline to answer
Ethnicity: Hispanic/Latinx - Non Hispanic or Latinx - other_____ - Decline to answer

Individual Responsible For Bill: Self / If other individual, fill in below:
Name: _____ **Phone #**: _____ **Relationship to you**: _____
Billing Address: _____ **City**_____ **State**_____ **Zip Code** _____

Emergency Contact: **Name**: _____ **Phone: Home/Cell?** _____
Relationship to you: _____

Current Employment: Full-time - Part-Time - Unemployed - Retired **Are you a Student?** Yes / No
Occupation: _____ **Second Occupation**: N/A _____**H2A Visa Worker?** Yes / No
Have you worked in agriculture within the last two years or are you retired from agricultural work? Yes / No
What type of Ag Worker? Seasonal Farmworker - Migrant Farmworker (Temporary home) - Retired Farmworker
Type of Work in Agriculture or on Farm?: Crops - Livestock - Nursery - Other: _____

Employer Name: _____ -Self-Employed
Address_____**City**_____**State**_____ **Zip Code**_____
Estimated Annual Household Income For Previous Year: $ _____ -Unemployed
If you were unemployed last year, what is your estimated income for this year?: $_____
Type of Income Verification Provided? Recent Pay Stubs **-** 1040 Tax Form - W2 - Employee Letter- Not Provided

Do you have Medical insurance? Yes / No
Insurance Provider:_____ **Subscriber #** _____**Group #**_____

Do you have Dental Insurance? Yes / No
Insurance Provider: _____ **Subscriber #** _____**Group #** _____

Consent Form

AG WORKER HEALTH & SERVICES

Consent to receive Healthcare Services

By signing this document, I hereby consent to receive medical, behavioral health, dental and/or preventive services from Ag Worker Health and Services. This may include, but is not limited to, medical evaluations, diagnostic testing, treatments, counseling, and health education provided by licensed and trained professionals.

Notice of Privacy Practices:

I acknowledge and understand that:

- I have been provided with a copy of Ag Worker Health and Service's Notice of Privacy Practices, which explains how my health information may be used and disclosed.
- Any updates to the Notice of Privacy Practices will be communicated to me promptly.
- All of my healthcare information will be kept private and secure under the federal law of HIPPA.

Verbal Communication Authorization: Would you like to allow anyone else to communicate with Ag Worker Health & Services about your healthcare? No - Yes

Name: _____ Relation to you: _____ Phone: _____

Name: _____ Relation to you: _____ Phone: _____

Financial Responsibility:

I acknowledge and understand that:

- I am responsible for any fees or charges associated with my care, including those not covered by insurance.
- I understand that my bill I will receive is based on Ag Worker Health & Service's sliding fee scale.
- It is my responsibility to inform the clinic of any changes to my insurance or financial situation.
- Although I may potentially qualify for vouchers or financial assistance with specific healthcare services, Ag Worker Health & Services does not guarantee they will be able to pay for any costs incurred for services received outside of the clinic, including but not limited to; specialist consultations, laboratory tests, advanced imaging (CT Scans, MRIs), Emergency Room visit, or other hospital services.

Consent for Communication: I consent to:

- Being contacted via phone, mail, email, or text for appointment reminders, test results, and clinic updates.

I prefer <u>not</u> to be contacted via: (circle one or more) phone call - mail - email - text

Telehealth Consent:

By signing this document, you consent to:

- Receive telehealth services. Telehealth involves the use of electronic communication to deliver healthcare services, including but not limited to video calls, phone consultations, and other forms of digital communication. I understand that there are potential risks such as technology failures, security breaches, or delays in care. Although efforts are made to protect your privacy and confidentiality, no system is entirely secure. **To Decline Telehealth Services, initial here _____**

Brief Explanation of Services: I acknowledge that:

- I have been provided with a copy of Ag Worker Health & Service's Brief Explanation of Services

I hereby certify that the information given on this patient intake form is true and accurate to the best of my knowledge. I understand that it is in my best interest to report all changes in a timely manner. I consent, acknowledge, and authorize that I have read and understand all information on this form and the forms provided such as Notice of Privacy Practices and Brief Explanation of Services.

_____ _____

Patient or Legal Guardian Signature | Date

_____ _____

If signed by legal guardian, please **<u>print</u>** name | Relationship to Patient

_____

Dependents/Children