Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

703 W Park St
Cayuga, IN 47928
Phone: (765) 492-9042
Fax: (765) 492-9048
Hours: Monday - Friday 8am - 5pm

CHILD PATIENT INFORMATION

Today's Date: _____

Patient Name: _____ Sex: ☐ M ☐ F (please check)

Physical Address: _____ Apt #:_____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County _____

SS#: _____ Date of Birth: _____

Home Phone: _____Cell: _____Work: _____

May we Email you? ☐ Yes ☐ No If so, e-mail address:_____

☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Student

Patient's Employer: _____

VPCHC is a Federally Qualified Health Center that receives government funding. The funding for *your* health center is based on information you provide and is necessary for us to better serve *you*, our patient. Please complete the following information for reporting purposes.

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

No. of People in Household: _____ ***Annual income:*** _____

Race: ☐ Multi-Race ☐ American Indian/Alaskan ☐ Black/African American

☐ Asian ☐ White/Caucasian ☐ Pacific Islander or Native-Hawaiian

Ethnicity: Hispanic/Latino ☐ Yes ☐ No ***Migrant Worker:*** ☐ Yes ☐ No ***Homeless:*** ☐ Yes ☐ No

Primary Language at Home: ☐ English ☐ Spanish ***Do you need an Interpreter?*** ☐ Yes ☐ No

Military Service: ☐ Non-veteran ☐ Veteran ☐ Active

Minor Child Consent to Treat

I give my permission for my child to be medically evaluated and treated at Valley Professionals Community Health Center in my absence. In addition, I give permission for the provider to share any relevant health information with the person accompanying my child. My child will be accompanied by:

___ himself/herself (only if 16 years of age or older)

___ relative/family member

Name: _____ Relationship: _____

___ other

Name: _____ Relationship: _____

If I am unable to bring my child for treatment at Valley Professionals Community Health Center, the individuals listed above may bring in my child for treatment which may include:

- physical examinations including screenings such as vision and blood pressure
- immunizations
- blood and/or urine tests
- first aid and emergency care
- prescription and treatment for illness
- referrals to an outside facility for services not provided in office (i.e., radiology, specialty)

I understand that this consent is only available for one year from the date of signature. If changes are needed to be made to the list at any time during the year, it will be necessary to complete a new form.

Parent's signature: _____ Date: _____

** Any person bringing a child in for treatment must bring in a picture ID (driver's license, state ID) so that we may keep a copy in the child's file.

Emergency Contact Information

Name: _____Relationship to patient: _____

Home Phone: _____Cell: _____Work: _____

Release of Protected Health Information

I, _____ (parent/guardian name), hereby authorize Valley Professionals Community Health Center to release/discuss _____ (patient's name) protected health information with the following individuals:

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

I understand I have the right to revoke this authorization, in writing, at any time by sending written notice to VPCHC. I understand that if I revoke the authorization, the revocation will not apply to information that has already been released in response to authorization or to information that VPHC has used based on this authorization. If I have questions about the use and disclosure of information, I can contact VPCHC.

Parent's signature: _____ Date: _____

Health History

Valley Professionals Community Health Center (VPCHC) uses a team-based approach to healthcare that works at improving primary care by providing comprehensive and continuous medical care. Our comprehensive care covers prevention and wellness, acute and chronic care as well as behavioral health. In order to provide the best patient care possible, it is essential that the information below be provided to ensure your personal provider and healthcare team understand your specific health concerns/needs. Each patient's personal provider and care team works to support the patient in learning to manage and organize their own care. In addition, the care team coordinates patient care with specialty groups, hospitals, home health and community services to ensure continuous, uninterrupted care.

Please complete the following information for your care team:

Primary provider: this is the provider who you will see on a regular basis

☐ Dr. Bing Gale ☐ Renae Norman, NP

Allergies
Please list everything the child is allergic to including medication, foods and environmental:

_____ _____

_____ _____

_____ _____

Surgery
Has the child had any surgeries? ☐ Yes ☐ No

List any surgeries below:

_____ _____

_____ _____

Is your child a smoker (13 years and older)? ☐ Yes ☐ No

Has the child ever had?

Asthma	☐ Yes ☐ No
Behavior problems	☐ Yes ☐ No
Bone infection or disease	☐ Yes ☐ No
Chicken pox	☐ Yes ☐ No
Concussion	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No

Has the child ever had?

Ear infections	☐ Yes ☐ No
Fracture or dislocation	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No
Hernia	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No
Kidney trouble	☐ Yes ☐ No
Measles	☐ Yes ☐ No
Mumps	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No
Scarlet fever	☐ Yes ☐ No
Seizures	☐ Yes ☐ No
Skin problems	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Urinary infections	☐ Yes ☐ No
Whooping cough	☐ Yes ☐ No

Health Insurance Information

Health Insurance: ☐ Yes ☐ No – see sliding fee scale information below

Please Note: We will file insurance as a courtesy to our patients. In order to file your insurance for you, we will need the proper insurance information. Please fill out the following information in order for us to file your insurance. If we are not able to collect from your insurance, you will be responsible for any services that are rendered.

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder (Name on card): _____

Date of Birth: _____ Relationship to patient: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder (Name on card): _____

Date of Birth: _____ Relationship to patient: _____

Responsible Party (Person Responsible for bill)

Name: _____ Relationship to patient: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____

Home Phone: _____Cell: _____Work: _____

Insured's Employer: _____

Sliding Fee Scale

The sliding fee scale is available to assist those patients that have no insurance or are under insured by offering our services at a discounted rate. Patients are required to apply for the sliding fee scale on a yearly basis. In order to qualify for the sliding fee scale at VPCHC, patients and their families must have a combined income that falls within the U.S. Federal Poverty Guidelines. The determination of qualification is based on the number of members in the household and the following information:

- Most recent tax filing with the IRS and/or W2's from employer(s).
- A copy of Social Security or Disability Award letter(s) or unemployment statement(s).
- Pay stubs from all employers for the last 30-day period.
- If unemployed, no income and living with others, we require a signed and dated letter from the person providing support of the patient.
- Driver's license or state ID card.
- Any other income that is direct deposited.

Upon request, a sliding fee scale application will be provided and should be returned with the information above within 10 days of the appointment. Otherwise, patient will be responsible for the full amount of charges.