Marram Health Center

Patient Registration (Please Print Clearly)

- **Photo ID:** Driver's license, State issued ID (adults), School ID (children)
- **Insurance Card: If applicable**
- **LIST OF ALL CURRENT MEDICATIONS**

HAVE YOU OR ANY IMMEDIATE FAMILY MEMBER TRAVELED OUTSIDE THE US IN THE PAST 30 DAYS? YES NO

Patient Demographic Information Section

FIRST NAME	MIDDLE NAME	LAST NAME	MAIDEN NAME (IF APPLICABLE)
HOME ADDRESS		APARTMENT/UNIT	CITY
STATE	ZIP	DATE OF BIRTH	COUNTY OF RESIDENCE	SOCIAL SECURITY #

SEXUAL ORIENTATION: STRAIGHT LESBIAN/GAY BISEXUAL DON'T KNOW PREFER NOT TO ANSWER

GENDER IDENTITY: TRANSGENDER FEMALE (MALE-TO-FEMALE) TRANSGENDER MALE (FEMALE-TO-MALE) MALE FEMALE OTHER PREFER NOT TO ANSWER

HOME OR PRIMARY PHONE (Only list if ok to call)	SECONDARY PHONE (IF APPLICABLE)

RACE: ASIAN AFRICAN-AMERICAN AMERICAN INDIAN CAUCASIAN UNKNOWN HAWAIIAN PREFER NOT TO ANSWER

ETHNIC GROUP: HISPANIC/LATINO NON-HISPANIC OR LATINO PREFER NOT TO ANSWER UNKNOWN

RELIGION	LANGUAGE SPOKEN

PATIENT'S EMPLOYMENT STATUS: NOT CURRENTLY IN LABOR FORCE SELF FULL TIME PART-TIME EMPLOYED RETIRED MILITARY

PATIENT'S EMPLOYER NAME (IF APPLICABLE)

MARITAL STATUS: MARRIED NEVER MARRIED DIVORCED WIDOWED

SPOUSE NAME (FIRST,LAST) (IF APPLICABLE)	SPOUSE'S SOCIAL SECURITY #

HIGHEST YEAR OF EDUCATION	CURRENT SCHOOL (IF APPLICABLE)	HOW DID YOU HEAR ABOUT US?	EMAIL

CIRCLE YES OR NO: ARE YOU A VETERAN? YES NO

CIRCLE YES OR NO: ARE YOU LIVING IN PUBLIC HOUSING? YES NO

Parent or Legal Guardian Information Section. To be completed if the Patient is a minor.

PARENT OR LEGAL GUARDIAN NAME (FIRST,LAST)	RELATIONSHIP TO CLIENT	DATE OF BIRTH		SOCIAL SECURITY #
PARENT OR LEGAL GUARDIAN HOME ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

Emergency Contact Information

NAME (FIRST,LAST)	RELATIONSHIP TO CLIENT	CITY	STATE	PHONE NUMBER

Primary Insurance or Medicare Information (If Applicable)

INSURANCE COMPANY NAME	EMPLOYER NAME	POLICY HOLDER ID #	INSURANCE GROUP #
POLICY HOLDER NAME (AS IT APPEARS ON CARD)	POLICY HOLDER SOCIAL SECURITY #	DATE OF BIRTH	BENEFIT CONTACT #

Marram Health Center

Housing Status

Please circle **yes or no** for the following questions:

Do you own your own home? (If you answered yes, stop here.)	Yes No
Are you living in a shelter?	Yes No
Did you just get housing within the last 12 months?	Yes No
Are you living on the street/abandoned housing?	Yes No
Are you living in a group home or transitional housing? (example: Kimbrough, Campagna)	Yes No
Are you staying with friends or family?	Yes No
Are you staying in temporary housing such as a hotel, motel, or campground?	Yes No
Are you living in a house or apartment, but your name is not on the lease?	Yes No

GENERAL CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

CONSENT FOR TREATMENT

I give Porter-Starke Services, Inc. (“PSS”) and Porter-Starke Services, Inc. dba Marram Health Center (“MHC”) permission to provide the diagnostic and treatment procedures that are deemed necessary by its medical and/or clinical staff. I recognize that the practices of both the psychological, psychiatric, and medical professions are not exact sciences and, therefore, I acknowledge that no guarantees have been made, or can be made, concerning the likelihood of success or outcome of any examination, test, diagnosis, treatment or therapy performed by PSS/MHC and its employees and contract personnel.

INDIANA DIVISION OF MENTAL HEALTH AND ADDICTION (DMHA)

I authorize PSS to release information to the Indiana Division of Mental Health and Addiction (DMHA) if the requirements are met under the terms of the DMHA Supported Consumer guidelines for community mental health center clients. DMHA Supported Consumer program allows us to offer sliding fee scales to the uninsured that meet the state guidelines. For all individuals meeting the following enrollment criteria: eligible diagnosis, family income at or below 200% of the Federal Poverty level, State of Indiana resident, Food Stamp recipient, TANF recipient, and/or a Medicaid recipient an Adult Needs and Strengths Assessment (ANSA) or a Child and Adolescent Needs and Strengths Assessment (CANS) will be conducted at the onset of treatment and at regular intervals during the course of treatment by your primary clinician. As a consumer you have the right to refuse enrollment, and you may cease your enrollment at any time.

SERVICES VIA TELEHEALTH

I recognize that some services are or may be provided via telehealth, which involves using electronic communications to enable a health provider at a location to serve an individual at another. Telehealth increases access to providers and offers the opportunity for continuous care. Telehealth equipment has security protocols to protect the confidentiality of the client’s identity and protected health information, and measures to safeguard against data corruption. In addition to risks associated with any clinical service, telehealth includes the risk of a mistake or delay due to equipment malfunction, poor image quality or loss of access to records, or security failure causing an unintentional privacy breach. It is expected that the benefits of telehealth will outweigh any increased risk. I understand that I may opt out of this treatment method without affecting my access to future services; I also understand that I have a choice to request telehealth or traditional in-person services. However, telehealth services may be the treatment method available during unforeseen or extreme circumstances (i.e. a public emergency) or may be the soonest types of services available. I understand that I will be asked to confirm my consent at each telehealth visit which includes my agreement that I have the necessary technology available to participate in a telehealth visit.

CONSENT FOR USE OF INFORMATION

By signing below, I give permission to PSS/MHC to send appointment reminders and emergency notifications via text or phone call. I recognize these are part of doing business and providing treatment. I consent to my photograph being taken for use in the electronic health record, to confirm my identity. I understand that PSS/MHC may securely use basic identifying information about me to access the Indiana Health Information Exchange (IHIE) CareWeb repository of healthcare data, which may contain information that may be beneficial to the provision of treatment at PSS/MHC.

SERVICE PROVISION

I recognize that provision of services is voluntary and I must adhere to the Client/Patient Rights and Responsibilities. Services are intended to be private and focused on treatment. I acknowledge by signing below that recording services without permission from PSS/MHC is counterproductive to treatment and thus not allowed by PSS/MHC unless written permission is given by the provider. I understand that noncompliance may result in termination of treatment with PSS/MHC.

PAYMENT TERMS AND ASSIGNMENT OF BENEFITS

- **Medicare**: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder from PSS, MHC, and/or the Inpatient Care Center of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I understand that I am responsible for the Part A and B Medicare deductibles, Medicare co-insurance and any personal charges incurred. I request that payment of authorized Medicare benefits be made on my

behalf for any services furnished to me by or in PSS/MHC, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I permit a carbon copy or photocopy of this authorization to be used in place of the original.

- **Medicaid**: I agree to pay the Medicaid co-pay amounts not paid by Medicaid.
- **Commercial Insurance**: I agree to pay the balance not covered by my insurance and I understand that amount is based on my plan type and benefit limitations. My Co-Insurance, Co-Pay and/or Deductible are due at time of service as estimated by the Client Financial Services Department. *Insurance companies do not guarantee payment.*
- If my insurance processes my claims and indicates that I owe more than was estimated, I will receive a monthly Statement that is payable upon receipt. I understand that other payment arrangements must be approved in writing, in advance, by PSS/MHC.
- In the event that this account is turned over for collection, I agree to pay any balance left due and owing, and I agree to pay all collection, interest, court cost and reasonable attorney fees, all without relief from valuation and appraisement laws.
- **Self-Pay:** If I am uninsured I may qualify for a discount based on my household income and number of dependents. Discounts are awarded by the information I give on the "Summary of Income" form. Fees will be reduced based on the current sliding fee scale and will be reviewed at least yearly (every 6 months for PSS clients and every year for MHC patients). The reduced payment is required at the time of service.
- Referrals to providers outside of PSS/MHC may be out of network with your health insurance company. Out of Network providers do not have to follow charge and payment arrangements that have been negotiated with your health insurance company. Therefore you may incur bills for services that exceed payment amounts that have been negotiated by your health insurance company. It is advisable that you contact your insurance company for information and assistance, including an in network provider list for this health care service.
- **I authorize and/or assign to PSS/MHC payment of government and/or third party medical benefits for services provided.**

Porter-Starke Services, **ICC Only:** □ **EDO** □ **Other Commitment** ______________ □ **Voluntary**

RELEASE OF INFORMATION

I authorize PSS/MHC to release any medical or other information to Medicare, Medicaid, and/or any third-party payer as necessary for processing claims for payment for services provided. I understand information covered under 42 CFR part 2 will require an additional authorization to release information.

X____________________________	____________________________	____________________
Client / Legal Guardian Signature	**Printed Name of Person Signing**	**Date**
____________________________	____________________________	
Relationship to Client	**Medical Record Number**	

INFORMATION GIVEN TO CLIENT

Initial items 1 through 2.

1. _______ I have received a copy of the Client/Patient Rights and Responsibilities. (Attached)
2. _______ I have received a copy of the HIPAA Notice of Privacy Practices. (Attached)
3. _______ **ICC Only**: I have received a copy of the Client Handbook.
4. _______ **ICC Only**: I have received notice that a physician is not present on the Inpatient Care Center 24 hours per day, 7 days per week.

For Staff use only below this line **For Staff use only below this line** **For Staff use only below this line**

PORTER-STARKE SERVICES, INC/MARRAM HEALTH CENTER

CLIENT NAME: ____

Directions: Scan into Streamline under "Scanned Consent to Treat"
Form Name: **General Consent for Treatment & Financial Agreement**
Form Rev. Date 06-13-11, 04-04-14, 12-11-17, 4-26-18, 11-5-18, 6/11/2020, 6/22/2023, 7/5/2023

Marram Health Center

Authorization for Disclosure of Protected Health Information
FOR INSURANCE COMPANY

Patient Name: ______________________ Date of Birth: ______________________

Patient Address: ______________________ City/State/Zip: ______________________

Phone: (   ) ______________________

The undersigned hereby authorizes and requests the release of confidential health information for review, examination and/or photocopies between **Marram Health Center, 3229 Broadway, Gary, IN 46409** and the listed **insurance company.**

Please Print Clearly

INSURANCE COMPANY NAME	POLICY HOLDER EMPLOYER NAME	POLICY HOLDER NAME (AS IT APPEARS ON THE CARD)	
POLICY HOLDER ADDRESS	POLICY HOLDER CITY	POLICY HOLDER STATE	DATE OF BIRTH

Access to this information is limited as designated below.

RELEASE IS VALID FROM THE DATE SIGNED UNTIL THE ACCOUNT IS SATISFIED WITH INSURANCE COMPANY

Portions Of The Medical Record to be Released to Insurance Company Include:
Bill codes, service dates, provider(s), and diagnosis
Notes and/or Treatment Plan and demographic information may be released if requested by the insurance company.

Purpose of Release:
To bill provided services to the insurance company and to communicate with the Insurance Company listed, the MCO (Managed Care Organization) or Carve-out plan as needed for authorizations, payment and continuity of care.

I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that I cannot be required to sign this authorization as a condition for having treatment provided or obtaining payment for the same.

Date, event or condition this authorization expires 60 days after services have been terminated or when all financial responsibilities have been satisfied with the insurance company. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the Health Information Department.

This information may be disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Signature: ______________________ Date: ______________________

Relationship to Patient: ______________________

Marram Health Center

Summary of Income

Please fill out this form to be reviewed for potential discounts. Staff can help if you have any questions.

Name of Each Household Member Please name each person in your household.	**Source of Income for Each Household Member** For each person, check all that apply.		**Yearly Income TOTAL for Each Household Member**
(Patient Name) 1)	❑ Wages ❑ Social Security ❑ Disability	❑ Unemployment ❑ Child Support ❑ Other:	$
2)	❑ Wages ❑ Social Security ❑ Disability	❑ Unemployment ❑ Child Support ❑ Other:	$
3)	❑ Wages ❑ Social Security ❑ Disability	❑ Unemployment ❑ Child Support ❑ Other:	$
4)	❑ Wages ❑ Social Security ❑ Disability	❑ Unemployment ❑ Child Support ❑ Other:	$
5)	❑ Wages ❑ Social Security ❑ Disability	❑ Unemployment ❑ Child Support ❑ Other:	$
6)	❑ Wages ❑ Social Security ❑ Disability	❑ Unemployment ❑ Child Support ❑ Other:	$
7)	❑ Wages ❑ Social Security ❑ Disability	❑ Unemployment ❑ Child Support ❑ Other:	$

I, the undersigned, hereby certify that the above statements are to the best of my knowledge true and complete.

I agree to notify Marram Health Center immediately if there is a change in my income or insurance status.

I also understand that if any of the above statements are determined at any time to be false, I will be responsible for payment of all past and future services at the full fee, plus any charges for collections, attorney's and court costs.

❑ **I refuse to provide income.** *I understand that my refusal to provide income disqualifies me from receiving any potential discounts for services.*

∗ Your signature is required on this form, whether you *agree* or *refuse* to provide income. ∗

Patient Signature: ____ **Date:** ____________________

Staff Signature/Title: ____ **Date:** ____________________

▸ *Staff: I am affirming I have reviewed with patient to verify and calculate the yearly income and number of household members.*

TOTAL Number of Household Members (including patient): _______ ▸ In EPIC, enter in "family size" under FPL Info	**TOTAL Yearly Income for Entire Household: $** ______________ ▸ In EPIC, enter Annual Income under FPL info

Patient Name: ____ Patient Account: ____________________________

Directions: Scan into EPIC

Revised: 06/13/11, 3/28/14, 9/25/15, 2/15/16, 12/12/19, 2/20, 2/21, 6/21, 7/21, 9/21, 2/22

Marram
Health Center

If You Need Another Family Member to Bring Your Child to Marram for Medical Care
OR
You Need Someone Else to Pick Up Forms/Prescriptions/Etc.

To be certain that we only allow people that you have approved to bring your child in for care, to pick up forms or prescriptions, or to act on your behalf in any way, please let us know who you approve for these purposes by completing the following:

Marram Health Center Approved List

Please print below the first and last name of approved individuals.	**Please list below your relationship with the approved individuals.** *(Examples: grandparent, sister, brother, friend or other relative)*	**Please list below what the approved individuals can do.** *(Examples: Bring child to Marram Health Center for care, pick up prescriptions and/or forms, needed shots or any other reason.)*

Please List the Children this Permission Applies to:

Print below the first and last name of child.	**Date of birth**	**Gender**

Your Name (print first and last): ____

Signature: ______________________________ **Date:** ______________________

Marram Health Center

Controlled Substance Agreement

Purpose: This agreement is to prevent misunderstandings about certain medications. It will assist patients, parents, and/or guardians as well as medical providers to follow the law regarding controlled substances. This contract may apply to acute and chronic pain patients, patients taking ADHD medication, or patients taking a controlled substance for other issues.

The medical provider agrees:

- To make a decision on whether or not to prescribe narcotic, scheduled or controlled medications based on if the medical provider believes the drug will benefit the patient;
- To prescribe which drug a patient will receive, at what dose, and for what length of time;
- To change or discontinue any medication that may not be in the patient's best interest;
- To refill medications at scheduled appointments;
- To monitor prescription activity using INSPECT;
- To follow guidelines or regulations regarding concurrent use of different controlled substances.

The patient (or parent/guardian) agrees:

- To store prescription medications safely and securely, ensuring that children do not have access to prescription medications;
- To notify the medical provider of any and all medications or treatments the patient is taking;
- To use the medication as prescribed and not adjust the dose;
- Not to request medication from another medical provider that a Marram Health Center medical provider is currently prescribing;
- To notify Marram Health Center immediately if narcotic, scheduled or controlled medications, such as opioid pain medications, controlled stimulants or anti-anxiety medication is prescribed due to an emergency situation from any other medical provider, dentist, or emergency room;
- Not to share, sell or trade medications with anyone. This is both illegal and dangerous;
- Not to request early refill of medications that have been damaged, flushed, spilled, or misplaced. Marram Health Center generally does not replace lost or stolen medications;
- To take prescriptions for controlled medications to one pharmacy;
- To allow Marram Health Center nursing staff to conduct a pill count of medication prescribed by a Marram Health Center medical provider at any time to ensure medication compliance;
- To notify medical providers if the patient is female and becomes pregnant;
- To periodic urine drug testing as the medical provider deems appropriate;
- Not to engage in the dangerous behavior of combining controlled substances with illegal substances.

As a patient of Marram Health Center, I agree to these guidelines which have been fully explained to me. I understand that it will be at the medical provider's discretion to order a urine drug test for me, and/or my child. Refusal to give a urine sample will be considered failing the test. A copy of this document has been given to me. I fully understand that if I and/or my child do not follow the terms listed above, the medical provider may discontinue prescribing any controlled substance, and that I and/or my child may be dismissed from the clinic. Altering prescriptions will mean immediate dismissal and notification of legal authorities.

______________________________	______________________________
Patient Signature	*Parent or Guardian Signature*
______________________________	______________________________
Witness Signature	*Date*

PORTER STARKE SERVICES
Health • Balance • Hope

Marram Health Center
Your partner in total health.

Authorization for Electronic Communication

This form does not apply to verbal telephone or fax communication, or appointment reminders sent via verbal phone call or text.

Client Name (please print): ____ Date of Birth: __________________________

Client Address: ____City/State/Zip: _________________________

Client Account Number: ______________________________

Please mark one box:

❑ **I request and give permission** for Porter-Starke Services and/or Marram Health Center to communicate with me electronically via text, email or other electronic means as is necessary to provide my treatment and other business needs related to the services I receive. I understand these communication methods are using **unsecure text messaging and/or unsecure email**. I understand that by providing my information and requesting electronic communication, that I am accepting the risk for a possible unauthorized disclosure. I understand if I share my phone account or email account with another person outside of Porter-Starke/Marram, that person would be able to view my private health information. If my phone # or email address below changes, I am responsible to update that information and submit an updated Authorization for Electronic Communication form. If my information is disclosed without my authorization, or my device(s) is/are lost or stolen, I will not hold Porter-Starke Services or Marram Health Center responsible for any disclosure that may occur.

❍ **Text/Phone Number:** (_______) ____________________ ❍ **Fax Number:** (_______) ____________________

❍ **Email:** ____

By signing below, I attest that the text/phone number, fax number or email address provided above solely belongs to me, or I have given permission to share with another person. I understand that secure communication methods are available to me but I am declining to use the secure communication method, and am choosing to use unsecure electronic communication.

I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that records not protected by Federal confidentiality rules (42CFR Part 2) may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I cannot be required to sign this authorization as a condition for having treatment provided or obtaining payment for the same.

Date, event or condition this authorization expires:_____________________. If no date, event or condition is specified, this authorization expires 60 days after services have been terminated or when all financial responsibilities have been satisfied. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written or oral revocation request to the Health Information Department.

❑ **I decline** for Porter-Starke Services and/or Marram Health Center to communicate with me electronically via text, email or other electronic means as is necessary to provide my treatment and other business needs related to the services I receive.

Client/Guardian Signature: ____Date: ______________________________

Relationship to Client: ____

Marram Health Center

Patient Support Survey

Health starts - long before illness - in our homes, schools, and jobs. The more we know about you, the better health care we can provide to you. We want to support your health and wellness.

Name: ____ **Date of Birth:** _________________________

Directions

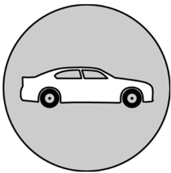
1. Please **check the boxes pictured below** that you would like more information about or assistance with. *We cannot guarantee to provide assistance in all areas, but we will do our best to respond to your priorities.*
2. Would you like to be contacted by a member of our healthcare team about your answers below?

❑ No, please do not contact me about this survey.

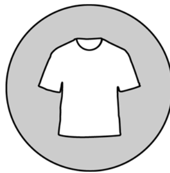
❑ Yes, please contact me about this survey. The best way to reach me is by:

- ❍ Phone: ____
- ❍ Email: ____
- ❍ Street Address: _______________________________________

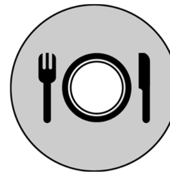
I am having a hard time getting access to and/or paying for...



❑ **Transportation**



❑ **Material Goods**
(clothes, diapers, furniture, etc.)



❑ **Food**

❑ **Education**

❑ **Housing**

❑ **Employment**

❑ **Utilities**

❑ **Physical Safety**

❑ **Mental Health**

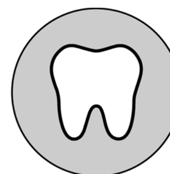
❑ **Health Insurance**

❑ **Legal Assistance**

❑ **Social Support**

❑ **Child Care**

❑ **Health Supplies**
(eyeglasses, medicine, etc.)



❑ **Dental**

❑ **Other:**____________