



**PeaceHealth
Medical Group**

Welcome to Outpatient Behavioral Health Services!

We look forward to seeing you at your upcoming visit. Please complete the attached paperwork and bring it with you to your appointment. We look forward to serving you!

Date and Time of appointment: _____

Your appointment is scheduled with: _____

Office Suite and Phone #: _____

- If you need to cancel your appointment, we have a *24-hour cancellation policy*. If you miss your first appointment, it is possible that you may not be rescheduled.
- Paperwork is necessary to complete your registration. *If you do not arrive early enough to check in and finish the paperwork before your appointment time, you may be asked to reschedule.*
- We do our best to verify insurance benefits and get authorization if one is required. If your insurance requires referral from your PCP we ask that you contact and request this to be submitted to your insurance prior to appointment.
- Parent/Guardian attendance may be required during the entire appointment time, which is generally between 60-90 minutes. In order to be efficient and focused on the child being evaluated, *we strongly recommend that you do not bring other children to the appointment.* If other children need to be with you, please bring another adult that can attend to the other children

If you have any questions or need to reschedule your appointment, please call New Patient Schedulers at 458-205-6426. If needing to fax paperwork back please use Fax Number 458-205-6708



Adult Behavioral Health
1200 Hilyard St.
3rd Floor, Suite 310
Eugene, OR 97401
Phone (458) 205-6709
Fax (458) 205-6708



Adult Behavioral Health
1200 Hilyard St.
4th Floor, Suite 460
Eugene, OR 97401
Phone (458) 205-6555
Fax (458) 205-6708



Child and Family Behavioral Health
1200 Hilyard St.
4th Floor, Suite 420
Eugene, OR 97401
Phone (458) 205-6444
Fax (458) 205-6708



UCare Clinic
1200 Hilyard St.
4th Floor, Suite 450
Eugene, OR 97401
Phone (458) 205-7131
Fax (458) 205-6708



Young Adult Behavioral Health
1200 Hilyard St.
5th Floor, Suite 570
Eugene, OR 97401
Phone (458) 205-7070
Fax (458) 205-6708



Transition Team
770 E 11th Ave.
2nd Floor
Eugene, OR 97401
Phone (458) 205-7085

1. Child Information

Date: _____

Child's full name: _____ Preferred name: _____

Birth date: _____ Gender: _____

| | <u>Relationship</u> | <u>Phone number</u> |
|----------------------------------|---------------------|---------------------|
| Person completing form: _____ | _____ | _____ |
| Person with legal custody: _____ | _____ | _____ |
| Child living with: _____ | _____ | _____ |
| Address: _____ | _____ | _____ |
| (Street) | (City, State) | (Zip) |

2. Family Composition – Please list all the adults and children in the home where the child is living.

Is this home (check one) Biological Foster Adopted Other

| <u>Name</u> | <u>Birthdate</u> | <u>Relationship</u> | <u>Mental Health Diagnosis?</u> |
|-------------|------------------|---------------------|---------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Is there an open DHS case for this child? Yes No

If so, name of DHS caseworker: _____

Has DHS ever been involved with this child Yes No

If so, please provide additional details: _____

Place patient label here

MG 319 (11/30/2017)

PeaceHealth Medical Group
Behavioral Health Services,
Child History (Ages 1-17)
Page 1 of 4



BH Clinic Note

What are the primary concerns that bring you to treatment? _____

When did these things start to become a problem? _____

What things is your child good at? What do they like to do? _____

3. Has any event occurred during the child's life which has had a profound effect on him/her?
(examples: a death, physical, a move, a divorce, loss of job, remarriage, etc.) If so, please explain:

4. **Previous Evaluations** (for example; psychological evaluation, academic evaluation, evaluation of disability)

WHEN _____ WHERE _____ BY WHOM _____
What were you told? _____

5. Please list all schools attended including preschool or day care.

6. What are your goals for treatment?

MEDICAL INFORMATION

Medical History

| YES | NO | | YES | NO | |
|--------------------------|--------------------------|------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Birth defects | <input type="checkbox"/> | <input type="checkbox"/> | Hearing normal |
| <input type="checkbox"/> | <input type="checkbox"/> | Head/back injury | <input type="checkbox"/> | <input type="checkbox"/> | Frequent colds |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Ear infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Stomach complaints |
| <input type="checkbox"/> | <input type="checkbox"/> | Unconscious | <input type="checkbox"/> | <input type="checkbox"/> | Chicken pox |
| <input type="checkbox"/> | <input type="checkbox"/> | High temperature | <input type="checkbox"/> | <input type="checkbox"/> | Strep/Staph infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision normal | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |

7. Any complications during pregnancy or birth?

If so, please describe? _____

| List surgeries or hospitalizations | Date | Age of child |
|------------------------------------|------|--------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Place patient label here

MG 319 (11/30/2017)

PeaceHealth Medical Group
Behavioral Health Services,
Child History (Ages 1-17)
Page 3 of 4



BH Clinic Note

8. Development (Please report age in months or years)

First word _____ First crawled _____

First sentence _____ First walked _____

First sat unassisted _____ Toilet trained _____

Generally, was development early, later or average? _____

9. Any special medical precautions or allergies?

Place patient label here

MG 319 (11/30/2017)

PeaceHealth Medical Group
Behavioral Health Services,
Child History (Ages 1-17)
Page 4 of 4



BH Clinic Note

Client Symptom Checklist - Youth

| Mark the number of times you experience these symptoms on average in a given week. | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Occurrence of Behavior | 0 | 1-2x | 3-4x | 5+ |
| Aggressive Behavior | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Argumentative/Oppositional | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tantrums | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stealing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bed Wetting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Soiling in inappropriate places | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fidgety, Hyper (can't stay seated) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crying | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-Harm (cutting, hitting, banging head on wall) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lying | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Withdrawn | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Binging/Purging Food | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Negative thoughts about self (I am dumb, stupid, ugly) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Forgetful (chores, homework) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Suicidal thoughts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thoughts you can't control | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nightmares | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mark appropriate box. Describe if yes. | | | | |
| | | | YES | NO |
| Problems in school | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | | |
| Sadness/Grieving | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | | |
| Sexual Trauma | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | | |

| Mark appropriate box. Describe if yes. | | YES | NO |
|--|--|--------------------------|--------------------------|
| Night Terrors | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Property Destruction | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Fire setting | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Appetite Disturbance (eating too much or too little) | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Risk taking behaviors | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Sleep Disturbance | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Homicidal thoughts | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Running away | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Feeling down or depressed | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Difficulty with concentration | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Anxiety | | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe: _____ | | | |
| Check the statement that best describes your grades. | | | |
| <input type="checkbox"/> Mostly A's and B's | | | |
| <input type="checkbox"/> Mostly C's and D's | | | |
| <input type="checkbox"/> Failing grades | | | |

Place patient label here

MG 320 (9/21/2017)



Child/Young Adult - REGISTRATION INFORMATION

Patient Information:

Date: _____

First, Middle, Last Name: _____ Preferred: _____

Date of Birth: _____ SS#: _____

Gender: _____ Gender Assigned at Birth: _____ Pronouns: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Position: _____

PARENT/GUARDIAN

Parent/Guardian Name: _____ Preferred: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Position: _____

EMERGENCY CONTACT - OTHER THAN PARENT/GUARDIAN

CONTACT NAME: _____ RELATIONSHIP: _____

STREET ADDRESS: _____

City: _____ State: _____ Zip: _____

Home Phone number: _____ Work phone number: _____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME: _____

SUBSCRIBER NAME: _____ DOB: _____ Gender: Male Female**IF DIFFERENT THEN PATIENT** - Relationship: _____ Name on card: _____

MEMBER ID#: _____ Group #: _____ Phone #: _____

MEDICAL CLAIMS ADDRESS: _____

Behavioral Health Services Patient/Client Provider Responsibility Disclaimer Form

As a client of PeaceHealth Medical Group Behavioral Health Services, you have rights as well as responsibilities. Providers and staff of the department want to make sure your rights are respected and that you are informed about the following:

A clinical record, which is the property of PeaceHealth Medical Group, is maintained documenting all services provided to you by PHMG Behavioral Health providers. This record also contains information that may be received from other sources, including progress notes from physicians and other records that may be obtained with your written consent.

Information contained in the clinical record is confidential and will be released only to persons or agencies outside of PeaceHealth with your written consent (or your parents/guardian if you are a minor). Before giving your written consent to release information, please be sure that you understand what specific information is being requested, the release of information is needed and necessary, and by providing this information it will be beneficial to you.

Please note: There are legal, ethical and organizational policy exceptions to confidentiality, which may require your therapist to release your records. We want you to be fully aware of these exceptions:

As a patient of PHMG Behavioral Health, certain information will be released within the organization; e.g. transcription of notes regarding your visits, charge slips sent to the billing department, communications with physicians or other Behavioral Health providers involved in your care. All employees of this organization are bound by a code of confidentiality. Your health insurance company may reserve the right to review your chart. Care is always taken to protect your rights to privacy. Effort is made to disclose to others the least amount of information needed in order to provide good care and insure reimbursement.

If there is reasonable cause to believe that you are an imminent danger to yourself or someone else, your therapist may arrange for a hospitalization or emergency medical consultation; **notify law enforcement authorities, other family members, and the individuals who may be at risk.**

In the case of a situation of abuse or neglect of a child or vulnerable adult, your therapist may **be required** by Oregon Law to report the situation to the appropriate authorities. If this is a concern for you, please discuss this issue with your therapist.

According to law, if, **at any time** your health status becomes an issue of a legal proceeding, including Worker's Compensation, your therapy records would be subpoenaed. A valid subpoena or court order may require the release of records or testimony by your provider.

If you become involved in legal proceedings or litigation against PeaceHealth, or any of its employees, please be aware that your clinical records may be made available to those involved in the investigation and defense of the organization.

Please initial the following if treatment pertains to a child:

If your minor child is in treatment, be aware that a non-custodial parent who wants to learn about their child's treatment may have the right, as does the custodial parent, to review the child's treatment record and to discuss their child's care with the therapist.

Mental Health services at PeaceHealth Medical Group do not include evaluation for the purpose of resolving legal disputes involving current and previous patients.

If you have specific concerns about confidentiality, please do not hesitate to speak to your provider about them.

I read and understand the above. Client/Guardian initials: _____ **Date:** _____

Patient Identification:

PeaceHealth Medical Group SYS1114-OR (03/25/20)

Patient/Client Provider Responsibility Disclaimer - OR
1 of 4



Consents

PeaceHealth patients (or patient representatives, as appropriate) have the right to...

- Choose from available services in a setting and under conditions that are least restrictive and intrusive to your liberty and that provide the greatest degree of freedom;
- Religious freedom;
- An individualized written service plan and ongoing participation in the planning of services;
- Deny services without informed voluntary written consent except in a medical emergency or as otherwise permitted by law;
- Receive medication only for your individual clinical needs;
- A humane service environment that provides reasonable protection from harm, reasonable privacy and daily access to fresh air and the outdoors. Access may be limited when it would create significant risk of harm to you or others.
- Receive prior notification of involuntarily termination or transfer of services and notification of available sources of necessary continued services;
- Decline to participate in experimentation without informed voluntary written consent;
- Be free from abuse or neglect and to report any incident of abuse without being subject to retaliation;
- Have access to and communicate privately with any public or private rights protection program or rights advocate.
- Know that, to enhance patient safety, video or auditory monitoring may be done in some individual patient rooms, care areas or common areas.

PeaceHealth patients (or patient representatives, as appropriate) are responsible to...

- Participate in planning and decisions regarding your healthcare;
- Provide as accurate and complete as possible relevant medical history, symptoms and concurrent conditions prior to and during the course of treatment;
- Ask questions and inform providers when answers to questions are not clear or understood or if you cannot follow instructions or the treatment plan;
- Promptly report any changes in your health, concerns about their care and/or obstacles to following your treatment plan;
- Provide information necessary to determine the ability to pay for services and any other sources of payment for services;
- Respect the dignity and rights of others;
- Respect the property of other persons and of the medical center;
- Conduct yourself in a respectful way that protects and maintains the safety of the healthcare environment;
- Do your best to follow your agreed upon treatment plan to reach the best possible outcome of care;
- Respect and comply with the PeaceHealth Tobacco-Free Campus Policy.

Patient Identification:

PeaceHealth Medical Group SYS1114-OR (03/25/20)

Patient/Client Provider Responsibility Disclaimer - OR

2 of 4



Consents

Treatment Plan

You have the right to participate in forming your treatment plan and to ask why any form of treatment is recommended. You may at any time refuse treatment or request a change in the treatment approach. Please discuss this further with your provider.

Appointments & Emergencies

It is your responsibility to attend scheduled appointments. If you cannot keep your appointment, please call and cancel at least 24 hours prior to your scheduled appointment time.

If you have an urgent need during business hours, you may be referred to another Behavioral Health care provider. We typically cannot be interrupted in the middle of a session with another client. On the weekends or after hours, our answering service can locate us, and your call will be returned within 24 hours. If your provider is unavailable, you may be referred to another provider who is on call. In an afterhours emergency, if you can't reach a Behavioral Health provider, go to the Urgent Care Center at PeaceHealth Medical Group or to the Emergency Room at Sacred Heart Medical Center.

Therapy Fees

Our standard hourly fee is \$401.00 for psychiatrists, \$401.00 for nurse practitioners, \$349.00 for licensed psychologists and \$349.00 for licensed clinical social workers, psychologist associates and professional counselors.

However, charges will vary depending on the length and type of session (e.g. initial visits, family or group therapy). **The average therapy session is approximately 45 to 50 minutes in length.** You may also be charged for other services such as testing, phone calls, after-hour contacts and consultations with other professionals. Please feel free to discuss charges or fees with us. Your insurance company will be billed for covered services; however, you will be expected to pay for any fees which are not covered by insurance.

Provider Responsibility Disclaimer

I understand many insurance companies now require authorization for mental health services. I will notify my provider if my insurance company requires pre-authorization. It is the provider's responsibility to submit the necessary treatment plans in order to obtain pre-authorization; however, it is my responsibility to be aware of my insurance company's pre-authorization requirements and how many actual benefits I have remaining. Authorization for sessions does **NOT** guarantee available benefits. If my benefits run out, I will be personally responsible for my bill.

Client/Guardian initials: _____ Date: _____

Health Record Information

I understand my health care provider may enter protected health information related to my treatment into the PeaceHealth electronic record system.

I read and understand the above. Client/Guardian initials: _____ Date: _____

Risks & Benefits of Therapy

Therapy has both benefits and risks. Therapy has been shown to have benefits such as improved mood or relationships and resolutions of specific problems. Risks may include experiencing uncomfortable emotions such as sadness, anxiety or anger, recalling difficult aspects of your history or disapproval of significant others. There are no guarantees about how therapy will affect you.

Patient Identification:

PeaceHealth Medical Group SYS1114-OR (03/25/20)

Patient/Client Provider Responsibility Disclaimer - OR

3 of 4



Consents

Grievance Procedures

If you feel your rights have been violated, please discuss this with your provider. If you are not able to resolve the issue in this manner, you may discuss it with the Behavioral Health Manager (458-205-6444) or the Behavioral Health Regional Director (541-686-7376). Finally, if a grievance cannot be resolved in this manner, you should contact the Oregon State Board of Medical Examiners, the Oregon State Board of Psychological Examiners, the Oregon State Board of Clinical Social Workers, the State Board of Nursing or the State Board of Licensed Professional Counselors and Therapists.

Oregon Health Plans Declaration of Mental Health Treatment

The Declaration for Mental Health Treatment is an advance directive that allows consumers to make choices about the mental health treatment they may want to receive at some future time, when and if they are not capable of giving consent. It also lets a consumer appoint a friend or relative to make these choices for him or her. A completed Declaration form allows a doctor to treat a consumer even though the consumer cannot provide consent at the time. Declaration for Mental Health Treatment forms can be obtained by contacting the State of Oregon, Office of Addictions and Mental Health Division (AMH), 500 Summer Street NE, E86 Salem, Oregon 97301-1118. Phone: 541-945-5763 <https://www.oregon.gov/oha/HSD/OHP/Pages/Member-Rights.aspx>

Oregon Medicaid Clients Only:

I have received and signed a Declaration I do not wish to sign a Declaration at this time

Client/Guardian initials: _____ Date: _____

Advance Directive

Advance Directives are available at every PeaceHealth office. Please ask the receptionist for assistance.

I have read and understand the Client Rights and Responsibilities Statement included herein. I give the PeaceHealth Medical Group Behavioral Health Services permission to evaluate or treat me or my family.

I have received a copy of the “Client Rights and Responsibilities” form.

PeaceHealth Medical Group “Your Rights As A Patient” form given on Admission.

Signature of Patient/Person Authorized to Sign for Patient Relationship Date Time

Signature of Patient/Person Authorized to Sign for Patient Relationship Date Time

Signature of Patient/Person Authorized to Sign for Patient Relationship Date Time

Signature of Caregiver EHR User ID Date Time

Patient Identification:

PeaceHealth Medical Group SYS1114-OR (03/25/20)

Patient/Client Provider Responsibility Disclaimer - OR
4 of 4



Consents

BHS Outpatient New Patient Checklist

Please initial on the line to acknowledge that you have received information or signed the following documents.

- _____ Verified correct name, date of birth, phone number, address, employer information and emergency contacts
- _____ Supplied current insurance card and state ID
- _____ Received signature of acknowledgement for the “HIPPA Notice of Privacy Practices
- _____ Offered the right to decline anonymous genetic research (if over 18)
- _____ Received signature of “Consent for Treatment and Financial Agreement”
- _____ Offered sign up for MyPeaceHealth portal
- _____ Offered a copy of “Rights and Responsibilities of Patients”
- _____ Offered Oregon voters registration form
- _____ Obtained ROI’s and offered “Detailed Message and Patient Communication” form
- _____ Mental Health Declaration was offered with the opportunity to sign or decline
- _____ Received Appeals and Grievances process and example of form (Medicaid)
- _____ Received and completed MOTS form (Medicaid)
- _____ Offered Financial Assistance Forms

Initial / Signature of patient or person authorized to sign for patient – Relationship Date Time

Place patient label here

MG 618 (5/30/2019)

PeaceHealth Medical Group
Outpatient Behavioral Health
New Patient Checklist
Page 1 of 1



BH Admin Documents

Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at PeaceHealth.

PeaceHealth provides financial assistance in accordance with state and federal requirements to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. To view PeaceHealth's Financial Assistance Policy and additional information, please visit peacehealth.org.

What does financial assistance cover?

The hospital financial assistance covers appropriate hospital-based services provided by PeaceHealth depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application:

Please contact Customer Service at 877-202-3597. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- Provide us information about your family
Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income
- Attach additional information if needed
- Sign and date the form

Note: You do not have to provide a Social Security number to apply for financial assistance.

If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail, email or fax completed application with all documentation to:

PeaceHealth Patient Financial Services, PO Box 748632, Los Angeles, CA 90074-8632. Email: financialassistance@peacehealth.org
Fax: (360) 729-3047. Be sure to keep a copy for yourself.

To submit your completed application in person:

Please contact Customer Service for the closest drop-off location at 877-202-3597.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly! You may receive bills until we receive your information.



PeaceHealth Financial Assistance Application Form - **CONFIDENTIAL**

Please provide answers to each question. If it does not apply, write "NA". Attach additional pages if needed.

PLEASE MAIL COMPLETED APPLICATION TO PEACEHEALTH, PO BOX 748632, LOS ANGELES, CA 90074-8632

Guarantor Number _____

SCREENING INFORMATION

- Do you need an interpreter? Yes No *If Yes, list preferred language: _____*
- Does the patient receive state public assistance services such as Medicaid, TANF, Basic Food, or WIC?? (OPTIONAL) Yes No
- Is the patient currently homeless? Yes No Is the patient's medical care need related to a car accident or work injury? Yes No

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.

PATIENT AND APPLICANT INFORMATION

| | | |
|---|-------------------------|--|
| Patient First Name | Patient Middle Name | Patient Last Name |
| <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <i>May Specify:</i> _____ | Birth Date | Social Security Number (not required) |
| Person Responsible For Paying Bill | Relationship To Patient | Birth Date |
| | | <i>Note: You do not have to provide a Social Security number to apply for financial assistance</i> |
| Mailing Address | | Main Contact Number(s) |
| City | State | Zip Code |
| | | _____) _____ _____) _____ |
| | | Email Address: _____ |

- Employment status of person responsible for paying bill
- Employed** *Date of hire:* _____ **Unemployed** *How long unemployed:* _____
- Self-Employed** **Student** **Disabled** **Retired** **Other:** _____

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE** *Use additional paper if needed.*

| Name | Date of Birth | Relationship to patient | If 18 years old or older: Employer(s) name or source of income | If 18 years old or older: Total GROSS monthly income (before taxes): | Also applying for financial assistance? |
|------|---------------|-------------------------|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

All adult family members' income must be disclosed and proof included with completed application. Examples of income sources include:

- Wages ■ Unemployment ■ Self-employment ■ Workers Compensation ■ Disability ■ SSI ■ Child/spousal support ■ Work study programs (students) ■ Pension ■ Retirement account distributions ■ Other *Please explain:*

ADDITIONAL INFORMATION

Please use additional pages if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

- I understand that PeaceHealth may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.
- I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.
- By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

Signature of Person Applying _____

Date _____

If you have questions or need help completing this application: Please contact Customer Service at 877-202-3597. You may obtain help for any reason, including disability and language assistance. To view PeaceHealth's Financial Assistance Policy and additional information, please visit peacehealth.org.

PLEASE MAIL COMPLETED APPLICATION TO PEACEHEALTH, PO BOX 748632, LOS ANGELES, CA 90074-8632