The HEALTHY VIKES CLINIC

HEALTH CARE PROVIDED BY HealthLinc
YOUR COMMUNITY HEALTH CENTER®

VALPARAISO COMMUNITY SCHOOLS

mhs

The Healthy Vikes Clinic gives you the opportunity to be seen by a licensed healthcare provider through the telemedicine program located at Thomas Jefferson Middle School. An explanation of services offered by the Telehealth clinic is listed below.

DESCRIPTION OF SERVICES

- Diagnoses and treatment for acute illnesses and minor injuries such as strep throat, ear infections, rash, and influenza
- Limited laboratory testing
- Behavioral health services and referrals

Your insurance will be billed for services provided in the clinic. If you do not have insurance, services will be provided on a sliding fee scale based on household income. If you are uninsured, please contact HealthLinc at 1-888-580-1060 to assist you with trying to obtain insurance. The Healthy Vikes Clinic is NOT intended to replace your primary care provider.

STAFF, CONTACT INFORMATION, AND HOURS

Staff: Providers of HealthLinc Valparaiso
Contact: 1-888-580-1060
Hours: The Healthy Vikes Clinic will be open Monday-Friday from 6:30 a.m. - 11:30 a.m.
The Healthy Vikes Clinic will be closed during all school holidays.

For Office Use Only:	Circle One:	Intake or Renewal:	MCD	MCR	Private	Slide Fee	Patient #: _____

Today's Date:_____

HealthLinc
YOUR COMMUNITY HEALTH CENTER©

Patient Legal Name:	Date of Birth:
Patient Preferred Name:	Social Security:
Address:	Telephone:
City: State: Zip code:	Township/County:
Email address:	US Resident: ☐ Y / N ☐ Veteran: ☐ Y / N ☐
Emergency Contact: Relationship:	Telephone:

List all individuals living in household (list each separately, INCLUDING THE PATIENT):

Name	M/F	Age	Date of Birth	Relation	SSN

Gender Identity	
Male	
Female	
Transgender Male/ Female-to-Male	
Transgender Female/ Male-to-Female	
Other	
Declined to answer	

Marital Status	
Single	
Married	
Separated	
Divorced	
Widowed	

Monthly Household Income	
None	$
Wages-Gross	$
Disability	$
Unemployment	$
Social Security	$
Workman's Comp	$
Monthly Total	$
Annual Total	$

Sexual Orientation	
Straight	
Gay	
Lesbian	
Bisexual	
Other	
Unknown	
Declined to answer	

Employment	
Full Time	
Part Time	
Self-Employed	
Retired	
Seasonal	
Unemployed	

Annual Household Income	
$0-20,000	
20,001-50,000	
50,001-100,000	
100,001+	

Homeless	
Homeless Shelter	
Transitional	
Doubling Up	
Street	
Other	
Unknown	

Race	
Black/African-American	
Asian	
Native Hawaiian	
Other Pacific Islander	
American Indian/Alaskan National	
White	
More than one race	
Refused	

Insurance	
Patient Refused Intake	
Uninsured	
Medicare	
Medicaid	
Medicaid Pending	
HIP	
Private Insurance	

Primary Language	
English	
Spanish	
Other	
Do you need an interpreter?	

Ethnicity				
Are you Hispanic/Latino?	Yes		No	

Preferred Communication Method					
Text		Email		Voice	

Preferred Pharmacy
Address:

It is my responsibility to keep HealthLinc informed of any change in address, phone number, income, and/or health coverage.

I understand that the information which I submit is subject to verification by HealthLinc, federal and/or state enforcement agencies, and others as required. Under penalty of perjury and/or fraud, I affirm that the above information is true and correct.

_____ _____

Applicant (signature) ***Applicant*** (printed name)

(The section below is for Office Use Only)

Proof of Income Provided (circle one): ☐ *Yes* ☐ *No* *Medical Slide Fee _____ Dental Slide Fee _____* *Renewal Due _____ Entered _____ Date: _____ Scanned: _____*

Adult Telehealth Consent:

To provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initialing the areas indicated and/or by providing your signature below.

Consent of Treatment:

- I consent to be seen by a licensed health care provider through and by the Healthy Vikes Clinic. I have received information about and understand the nature of the treatment provided at the Healthy Vikes Clinic, the way it is provided, and the details and limitations of this form and style of treatment.

_____ (I**nitials)**

- I understand that this consent constitutes the establishment of a Physician-Patient relationship between myself and any Provider, employed by HealthLinc, Inc., who examines me through the Healthy Vikes Clinic for all visits.

_____(Initials)

- I understand that I may be contacted after my visit to discuss my diagnosis, treatment options and any need to seek in person care.

_____(Initials)

- I authorize the release of any information necessary to process insurance claims for payment of benefits to HealthLinc, Inc.

_____(Initials)

- I authorize payment of benefits to HealthLinc Inc. for services rendered, and have provided details of all insurance policies.

_____(Initials)

Release of Information: Following each visit to the Healthy Vikes Clinic, a visit summary will be provided to you, and can also be provided to your primary care provider. Please check the appropriate box below regarding providing a summary of your visit to your primary care provider.

- I would like the Healthy Vikes Clinic to provide a written summary to my primary care provider. I understand this information may include drug and alcohol, mental health, HIV/AIDS test results and/or genetic testing, and this authorization is valid unless cancelled by me in writing.

_____(Initials)

_____ **_____**

Primary Care Provider Name **Phone**

_____

Address

- I DO NOT want the Healthy Vikes Clinic to provide a written summary to my primary care provider.

_____(Initials)

Notice of Privacy Practices

HealthLinc is committed to protecting your personal health information in compliance with the law. A copy of the Notice of Privacy Practices and any Addendum are available upon request. (Available in the Healthy Vikes Clinic or TJ Middle School nurse's office)
I hereby acknowledge that I have received/been offered a copy of the Notice of Privacy Practices and any Addendum.

Signed: _____**Date**: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency prevented us from obtaining acknowledgment
- Other (specify)_____ Staff Initials: _____

Adult Telehealth Medical History

Name:_____ Date of Birth:_____

Allergies:

Medications?

_____

_____

Foods/Latex/Other?

_____

_____

Current Medications (and over the counter drugs, herbs, birth control):

_____

_____

_____

Do you now have or have you ever had any major medical issues?

☐ *Yes* or *No* ☐

If YES, please list:

_____

_____

Do or did you smoke cigarettes?

☐ *Yes* or *No* ☐

If yes, how much: _____ How many years? _____

Date of last menstrual period: _____