Welcome to Esse Health!

At Esse Health, we are dedicated to patient satisfaction, service and value. Our Mission is to place you and your physician at the center of every health care decision. We know your choice of a physician is an important decision, and we are committed to providing the highest quality care by working with you to maximize your health. We call it patient-centered care.

What does patient-centered care mean for you? It means you have a team of health care professionals, led by your physician, who can help you be more involved in your health care and take better care of yourself. It means you have access to resources like our Patient Portal that allows you to ask a medical question, request an appointment or refill a medication at times that are convenient for you. And it means we provide the highest quality care in the most cost effective way. The National Committee on Quality Assurance (NCQA) has recognized Esse Health as a Level 3 Patient-Centered Medical Home.

Thank you for choosing Esse Health as your partner in healthcare. We are committed to you and your family's good health.

Best Wishes,

Mike Castellano
Chief Executive Officer
Esse Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize the use or disclosure of the above-named individual's health information as described below.

INFORMATION TO BE RELEASED **BY:**

_____
Organization/Person Name

_____ _____
Address City, State, Zip

INFORMATION TO BE RELEASED **TO:**

_____
Organization/Person Name

_____ _____
Address City, State, Zip

TYPE OF MEDICAL INFORMATION TO BE DISCLOSED

□ Complete Medical Record □ List of Allergies □ X-ray reports
□ Physician Progress Notes □ Problem list □ EKG
□ Immunization Records □ Lab Reports □ Medication list
□ Consultation Reports □ Other (please specify) _____
□ My health information relating only to the following treatment/condition_____
□ My health information only for the following dates: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby **specifically authorized to release** all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded below.

_____

I understand I have a right to cancel this authorization at any time. I understand if I wish to withdraw this authorization, I must do so in writing. I must present my written cancellation to the health information management department. I understand the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date or event _____. If I fail to specify an expiration date or event, this authorization will expire in six months.

I understand authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to receive treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager. I understand there may be a charge associated with copying my health information.

_____ _____
Signature of Patient/Legal Representative Date

Patient Name:_____ Date of Birth:_____

AUTHORIZATION TO COMMUNICATE INFORMATION TO PATIENT

The undersigned authorizes Esse Health, its physicians, staff and representatives to communicate with me by leaving messages related to my healthcare at the following numbers:

Home:_____ Cell: _____ Work: _____

AUTHORIZATION TO COMMUNICATE INFORMATION TO OTHERS

The undersigned authorizes Esse Health, its physicians, staff and representatives to communicate information about my health with the following:

1. Name: _____ Home #:_____
   Relationship to Patient: _____ Cell #: _____
   Work #: _____

   May Discuss Diagnosis/Treatment: Yes _____ No_____
   May Discuss Billing Info: Yes _____ No _____

2. Name: _____ Home #: _____
   Relationship to Patient: _____ Cell #: _____
   Work #: _____

   May Discuss Diagnosis/Treatment: Yes ____ No _____
   May Discuss Billing Info: Yes _____ No _____

I understand that these authorizations are voluntary and that I can refuse to sign the authorization. I understand I may revoke this authorization at any time. I understand I do not have to sign this form to receive care. I understand it is my responsibility to update this list in order to keep accurate who can obtain information about my health.

_____ Date:_____
Patient/Legal Representative

SIGN BELOW ONLY IF YOU WISH TO REVOKE YOUR AUTHORIZATION

I hereby revoke this authorization.

_____ **Date:** _____
Patient/Legal Representative

ADULT REGISTRATION/UPDATE FORM

PATIENT INFORMATION

TODAY'S DATE _____

Last Name	First Name	Middle Initial
Home Phone	Work Phone	Cell Phone
E-mail Address	Date of Birth	Age
Home Address Street	City State Zip	Social Security Number
Occupation	Employer Name	Zip
Employer Address Street	City State	

Birth Sex	☐ Female	☐ Male	☐ None	☐ Undifferentiated ☐ Unknown
Current Gender	☐ Female	☐ Male	☐ None	☐ Undifferentiated
Gender Identity	☐ Female ☐ Female-to-Male (FTM) Transgender Male/ Trans Man	☐ Male ☐ Male-to-Female (MTF) Transgender Female/ Trans Woman	☐ Genderqueer/Non-Binary Neither Exclusively Male or Female	☐ Choose Not to Disclose ☐ Additional Gender Category or Other Please Specify
Sexual Orientation	☐ Straight or Heterosexual ☐ Don't Know	☐ Lesbian, Gay or Homosexual ☐ Something Else, Please Describe	☐ Bisexual ☐ Choose Not to Disclose	☐ None
Preferred Pronoun	☐ She, Her, Hers ☐ Other	☐ He, Him, His ☐ None	☐ They, Them, Theirs ☐ Asked, but Unknown	☐ Ze, Hir ☐ Decline to Answer
Marital Status	☐ Single ☐ Annulled ☐ Domestic Partner	☐ Married ☐ Widowed ☐ Polygamous	☐ Divorced ☐ Interlocutory ☐ Unknown	☐ Legally Separated ☐ Life Partner

HEALTH INSURANCE INFORMATION

MUST BE COMPLETED FOR ESSE HEALTH TO BILL YOUR INSURANCE COMPANY

PRIMARY INSURANCE		SECONDARY INSURANCE	
Name of Insurance Plan		Name of Insurance Plan	
Name of Person Who Carries Insurance		Name of Person Who Carries Insurance	
Insurance Identification Number		Insurance Identification Number	
Group Number or Name of Employer		Group Number or Name of Employer	
Date Insurance Began		Date Insurance Began	
[ ] HMO [ ] PPO [ ] OTHER		[ ] HMO [ ] PPO [ ] OTHER	
COPAY		COPAY	

PLEASE COMPLETE FOR SPOUSE (IF MARRIED) OR PARENT (IF DEPENDENT)

Last Name First Name	Middle Initial	Relationship to Patient
Home Phone	Work Phone	Cell Phone
E-mail Address	Date of Birth	Age
Home Address Street	City State Zip	Social Security Number
Occupation		Employer Name
Employer Address Street	City State	Zip

ADULT REGISTRATION/UPDATE FORM

PATIENT INFORMATION

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I, _____, acknowledge that I am responsible and liable for all charges assessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Esse Health. I understand that I am responsible for meeting my insurance deductibles and coinsurance and any non-covered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize the release to my insurance company of any medical information necessary to process a claim and hereby assign payment of all medical benefits to Esse Health.

Signature _____ Date _____

IN CASE OF URGENT NEED, PLEASE CONTACT THE FOLLOWING PERSON

Name _____ Relationship to Patient _____

Phone Number _____

HOW DID YOU HEAR ABOUT US?

- ☐ Physician
- ☐ Hospital
- ☐ Internet/Social Media
- ☐ Insurance Company
- ☐ Friend/Relative
- ☐ Yellow Pages
- ☐ Newspaper
- ☐ Other _____

Date: _____

Patient Information Sheet

Last Name | First Name | Date of Birth

PATIENT DEMOGRAPHIC QUESTIONNAIRE

Please note that we are requesting this optional information as an attempt to comply with Federal "Meaningful Use" guidelines, as released by The Office of the National Coordinator for Health Information Technology. More information regarding these guidelines is available at http://healthit.hhs.gov.

You are NOT obligated to respond in order to be treated.

If you do not wish to provide this information, please simply fill in your name, date and select the "Decline to Respond" choice.

Please select the below as appropriate:

RACE

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Decline to Specify
- ☐ Other Race

PREFERRED LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Bosnian
- ☐ Russian
- ☐ Italian
- ☐ French
- ☐ German
- ☐ Chinese
- ☐ Japanese
- ☐ Central Khme
- ☐ Haitian; Haitian Creole
- ☐ Hebrew
- ☐ Portuguese
- ☐ Korean
- ☐ Somali
- ☐ Arabic
- ☐ Spanish Castilian
- ☐ Vietnamese
- ☐ Hindi
- ☐ Polish
- ☐ Thai
- ☐ Other
- ☐ Bulgarian
- ☐ Urdu
- ☐ Swahili
- ☐ Decline to Specify

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Specify

CONTACT PREFERNCE

- ☐ Cell Phone
- ☐ Confidential
- ☐ Email/Portal
- ☐ Home Phone
- ☐ Mail
- ☐ Work Phone
- ☐ Decline to Specify