communityclinic
A HEALTHCARE MINISTRY OF ST. FRANCIS HOUSE NWA

Patient Information

*Account#*_____

Last Name _____ First Name_____ MI ___

Address _____Apt #_____

City_____State.____ Zip _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

Email Address _____

I prefer to be contacted by Community Clinic via: ☐ Text ☐Email ☐ Phone **Check all that apply*.

Date of Birth ____ ____ ____ Social Security Number ___-___-____* Required field for all insured patients.
Month Day Year

Pharmacy _____

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race **Check all that apply* ☐American Indian or Alaska Native ☐Asian ☐ Black or African-American
☐ Native Hawaiian ☐Other Pacific Islander ☐ White ☐ Other Race

Gender: ☐Male ☐Female

Gender Identity: * For patients 18 and over ☐Male ☐Female ☐Transgender Male
☐Other ☐Choose not to disclose ☐Transgender Female

Sexual Orientation * For patients 18 and over ☐ Straight (not gay or lesbian) ☐ Lesbian or Gay ☐ Bisexual
☐ Something else ☐ Don't know ☐ Choose not to disclose

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated ☐ Living with partner

Employment Status ☐ Employed full time ☐ Employed part time ☐ Unemployed and seeking work
☐Otherwise unemployed but not seeking work (ex. Retired, disabled, unpaid primary care giver)

Employer _____

Student Status ☐Full time student ☐ Part time student School Name _____

Emergency Contact _____ Relation _____
Address _____Phone ( )_____
City_____State._____ Zip _____

Preferred Language ☐ English ☐Spanish ☐ Marshallese ☐Other _____

Do you need a translator/interpreter? ☐ Yes ☐ No

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Are you a veteran? ☐Yes ☐ No

How did you hear about Community Clinic?
☐Friend or family member ☐Doctor's office ☐Emergency room
☐ Social service agency ☐School ☐Connect Care/Medicaid ☐Walk in
☐Radio/newspaper ☐Internet/Social media ☐Health Department

Please provide the following insurance information:

Name of Insurance Company _____ Policy Number _____

Policy Holder's Name _____ Date of Birth _____

Policy Holder's Social Security Number _____* Required field.

Group Number _____Group/Employer Name _____

Discounts are available for those who qualify. Please ask staff for more information.

In order to protect your privacy, Community Clinic asks you to list family members, friends, or any person(s) who can access or inquire about your Protected Health Information (PHI). This includes being able to make and change appointments, talk about visits, medications and treatments, and ask about account balance.

This authorization may be amended or revoked at any time with written notice to the Clinic.

I, _____, give Community Clinic permission to allow the following people to access or inquire about my Protected Health Information:

For patients under 18 years of age, please include information for all parents/guardians with custodial rights.

Last Name _____ First Name_____ MI ____

Relationship_____ Date of Birth _____ Primary Phone _____

Address _____Apt #_____

City_____State____ Zip _____

Last Name _____ First Name_____ MI ____

Relationship_____ Date of Birth _____ Primary Phone _____

Address _____Apt #_____

City_____State____ Zip _____

Last Name _____ First Name_____ MI ____

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Relationship_____ Date of Birth _____ Primary Phone _____

Address _____Apt #_____

City_____State____ Zip _____

Patient's Last Name_____ Patient's First Name _____ Patient's MI _____
Patient's Date of Birth (mm/dd/yyyy) _____

PERMISSION FOR MEDICAL OR DENTAL TREATMENT:

- I give permission for the provider and his / her staff to administer needed treatment to patient.
- I understand that no guarantees can be made about treatment results.
- I give permission for supervised students to be present during my visit but I can ask them to leave at any time.

APPOINTMENTS:

- I agree to arrive on time for my appointments.
- I understand I need to call the clinic 24 hours ahead of time to cancel an appointment.
- I understand if 3 appointments are missed (without 24 hour notice) I / patient may be dismissed from care.

PRIVACY NOTICE:

- I had the opportunity to read and request a copy of Community Clinic's Notice of Privacy Practices (HIPAA Form).

PAYMENT RESPONSIBILITY:

- I will provide insurance information to Community Clinic and will allow necessary medical/dental history, diagnosis, and treatment information to be shared for the purposes of filing insurance claims and receiving insurance payments.
- I understand I am expected to pay Community Clinic for my services provided.

MEDICATION REFILL:

- All medication refills requests may take up to 72 hours. If a request is made on a Friday it may not be completed until Tuesday. Patients are advised to make medication requests five (5) days prior to running out of medications to avoid delays in fulfilling request.

_____ MEDICAL RECORDS DATA ACCESS:

(Initial Here)

- I agree that my protected health information will be made available electronically through an electronic health information exchange to other health care providers and health plans that request my information for treatment and payment purposes. I understand that participation in an electronic health information exchange also lets Community Clinic see information about me for treatment and payment purposes. I agree to have my information disclosed to health care payer and the health information exchange.
- I agree to have my medical records used for program evaluation projects and professional research data collection with the understanding that all personal, identifying information will be removed.

THIS FORM MUST BE SIGNED BY THE PATIENT OR THE PATIENT'S PARENT/GUARDIAN BEFORE TREATMENT CAN BE PROVIDED.

I, _____, have read and understand this document.
(Print Name of Patient / Parent / Guardian on the line above)

_____ _____
Patient / Parent / Guardian Signature Date

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