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

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

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Please provide the information for the person responsible for payment of this account (guarantor):

Guarantor Last Name _____ First Name _____ MI ___

Street Address_____Apt #_____

City_____ State ____ Zip _____

Patient's Relationship to Guarantor ☐Self ☐Child ☐Spouse ☐ Guardian ☐ Other

Social Security Number _____ Date of Birth _____ Sex M ___ F ___

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

Guarantor's Employer_____

Employer Address _____Phone ( )_____

City _____ State _____ Zip _____

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.

For patients under 18 years of age, please provide information for parents with custodial rights:

Last Name _____ First Name_____ MI ____

Relationship_____Primary Phone _____

Address _____Apt #_____

City_____State____ Zip _____

Last Name _____ First Name_____ MI ____

Relationship_____Primary Phone _____

Address _____Apt #_____

City_____State____ Zip _____

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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:
(Initial Here)

- 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:
(Initial Here)

- 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:
(Initial Here)

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

_____ 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.

_____ PAYMENT RESPONSIBILITY:
(Initial Here)

- 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:
(Initial Here)

- 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.

_____ PRESCRIPTION DRUG ASSISTANCE:
(Initial Here)

- We are able to participate in programs that offer certain medications for free or at a reduced price. You may be able to qualify to participate in one of these programs. ANNUAL ENROLLMENT FOR THIS PROGRAM IS $25.00.
- The Prescription Assistance Program may require that you disclose your financial status, illness, and/or treatment to the drug manufacturing company. Your signature is required on certain forms.
- By signing below, you authorize the pharmacy reimbursement specialist to sign as your agent for the required application and other forms that may be required by the medication assistance programs.

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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Community Clinic serves as a Patient Centered Medical Home for our patients. This means that one of our goals is to provide resources to help patients be more successful in caring for themselves and their families. By answering the questions below, patients can give us a better idea of resources that Community Clinic can help with.

What is your housing situation today?
☐ I have housing
☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, in a car, in a park, etc)
☐ I choose not to answer this question.

Are you worried about losing your housing?
☐ Yes
☐ No
☐ I choose not to answer this question.

What is the highest level of school that you have finished?
☐ Less than a high school degree
☐ More than a high school degree
☐ High school diploma or GED
☐ I choose not to answer this question.

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?
☐ Food
☐ Clothing
☐ Utilities
☐ Child Care
☐ Health care or medications
☐ Phone
☐ Other (please write) _____
☐ I do not have problems meeting my needs.
☐ I choose not to answer this question.

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? [Check all that apply]
☐ Yes, it has kept me from medical appointments or from getting my medications.
☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need.
☐ No.
☐ I choose not to answer this question.

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
☐ Less than once a week
☐ 1 or 2 times a week
☐ 3 to 5 times a week
☐ More than 5 times a week
☐ I choose not to answer this question.

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?
☐ Not at all
☐ A little bit
☐ Somewhat
☐ Quite a bit
☐ Very much
☐ I choose not to answer this question.