

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

Sexual Orientation Straight (not gay or lesbian) Lesbian or Gay Bisexual
* For patients 18 and over 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

Account# _____

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 _____

Relationship _____ Date of Birth _____ Primary Phone _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Account# _____

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