communityclinic

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 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 us?
☐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 following financial information:

As a Federally Qualified Health Center, we are required to collect income information on ALL patients even if you choose NOT to participate in the Sliding Fee Scale Program. Please choose your household gross income range:				
☐ $0 - $12,000	☐ $12,001 - $24,000	☐ $24,001 - $36,000	☐ $36,001 - $48,000	☐ $48,001 - $60,000
☐ $60,001 - $72,000	☐ $72,001 - $84,000	☐ $84,001 - $96,000	☐ $96,001 or higher	☐ Refuse to report

Number of people in your household: _____

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 _____

Guarantor's Name _____ Date of Birth _____

Guarantor's Address: _____

Phone Number _____

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 _____

**To list additional individuals, please see the front office.*

Patient's Last Name_____ Patient's First Name _____ Patient's MI _____

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*Account#*_____

Patient's Date of Birth (mm/dd/yyyy) _____

PERMISSION FOR MEDICAL OR DENTAL TREATMENT:

- I authorize the medical staff of Community Clinic to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
- I understand and acknowledge that no guarantees can or will 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.

PRIVACY NOTICE:

- I had the opportunity to read and request a copy of Community Clinic's Notice of Privacy Practices (HIPAA Form).
- I consent to be contacted by mail, email, phone or text regarding any matter related to my accounts where I am the guarantor.

PAYMENT RESPONSIBILITY:

- I will provide necessary medical/dental history, diagnosis, and treatment information to ensure proper care.
- I authorize my health insurance carrier(s) or other third-party payers responsible for payment for my health care, including Medicare, Medicaid and other governmental and commercial insurers, to pay the costs associated with health care services rendered to me by Clinic. I hereby assign to Clinic any rights I might have to receive payment directly from such insurance carriers and third-party payers and authorize my insurance carriers and third party payers to pay Clinic directly for the health care services provided to me.
- I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance (including copays, coinsurance, and deductibles) on my account for any health care services rendered by Clinic.
- I understand I am expected to pay Community Clinic for my services provided to me and/or my dependents.

_____ MEDICAL RECORDS DATA ACCESS:

(Initial Here)

- I consent and 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 payers 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.
- I agree to the release of my records for the purpose of care coordination between providers upon referral to specialist physicians or external medical practice facilities.
- I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I voluntarily authorize the disclosure of my SUD treatment Records as described below:
    - Information about your participation in Substance Use Disorder Treatment (SUD) (Alcohol or Drug);
    - Diagnosis and Treatment for SUD;
    - Medications prescribed for SUD Treatment;

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

Rev: 10/2024