PROMISE COMMUNITY HEALTH CENTER

Patient Information:

Full Name: _____ Date of Birth (MM/DD/YY) : _____/_____/_____
Last First MI

Social Security No.: ____ ____ ____ - ____ ____- ____ ____ ____ ____ Sex: ☐ Female ☐ Male

Address: _____ Apt/Lot #_____

City: _____ State: _____ Zip: _____

Email: _____ Employer/City: _____

Primary Contact Phone Number: _____ ☐ Home ☐ Mobile

Secondary Contact Phone Number: _____ ☐ Home ☐ Mobile

Secondary Contact Name: _____ Relationship to patient: _____

Preferred Language for your care at Promise: ☐ English (No interpreter needed) ☐ Spanish ☐ Other: _____

Financial Information:

How many people are in your household: _____
Household Income (Before Taxes):
$ _____ □ Monthly □ Annually

☐ Prefer not to disclose

Sliding Fee Discount Program

All patients with or without insurance are eligible to apply and receive possible discount on bill.
Separate application and proof of income required.

☐ Yes, interested in discount program

Guarantor (Person to be billed, Check here if same as patient ☐)

Name: _____

DOB: _____SSN: _____

Phone: _____

Address: _____

City, State, Zip: _____

Relationship to Patient: _____

Insurance Information:

Do you have Primary Insurance? ☐ Yes ☐ No

Insurance Plan Name: _____

Group Number: _____

Policy Number: _____

Name: _____

DOB: _____

Employer Name: _____

Relation to Patient: _____

Do you have Secondary Insurance? ☐ Yes ☐ No

Insurance Plan Name: _____

Group Number: _____

Policy Number: _____

Name: _____

DOB: _____

Employer Name: _____

Relation to Patient: _____

Ethnicity:

☐ Non-Hispanic Hispanic/Latino:

☐ Mexican or Mexican American ☐ Cuban ☐ Puerto Rican

☐ Other: _____

Racial Group(s):

☐ White/Caucasian
☐ Black/African American
☐ American Indian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian

Marital Status:

☐ Single ☐ Separated
☐ Married ☐ Divorced
☐ Life Partner ☐ Widow

Veteran Status:

Have you served in the United States Military or Armed Services?
☐ Yes ☐ No

Sexual Orientation:

Do you think of yourself as?

☐ Straight or heterosexual
☐ Lesbian, gay or homosexual
☐ Bisexual
☐ Prefer not to answer
☐ Don't Know
☐ Other: _____

Gender Identity:

Do you think of yourself as?

☐ Male
☐ Female
☐ Transgender Male/Trans Man/FTM
☐ Transgender Female/Trans Woman/MTF
☐ Gender Non-Conforming
☐ Other: _____

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☐ Samoan ☐ Don't Know/Decline			

HIPAA Privacy and Release of Information

Patient Name:_____Patient DOB: _____

Persons Authorized to Obtain Medical Information:

I give permission to Promise Community Health Center to disclose health and/or billing information to the individuals identified below that are involved in patient care or payment of care. I understand PCHC is not responsible for the information provided as long as it is given to a person listed below.

Note: If patient is child is below 18, parents do not need to be listed
If patient would like their spouse or partner to have access, the spouse/partner needs to be listed below

Name: _____ Name: _____

Relationship: _____ Relationship: _____

DOB: _____ Phone: _____ DOB: _____ Phone: _____

HIPAA Privacy and Release of Information Authorization: I hereby authorize PCHC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.
I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority. I acknowledge I have received the Notice of Privacy Practices and understand I may request a copy of Promise's Notice of Privacy Practices at any time.

Health Information Exchange: I understand that Promise participates in the electronic exchange of health information with other health care providers through South Dakota Health Link. Unless I choose to opt out, my electronic health information will be accessible through South Dakota Health Link to properly authorized users for purposes of treatment, payment, and health care operations only. To opt out or find out more, I can find information at sdhealthlink.org or ask for staff assistance.

Financial Responsibility: My signature below indicates that I accept financial responsibility for this account and for payment of services provided to me and to my spouse and/or my dependents.

I certify that the information I have provided is true and correct to my knowledge.

If signed by legal representative:
By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Patient/Guardian Signature: _____ Date: _____

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Relationship to patient: _____