

New Patients: Who referred you to Promise?

Name:

Phone Number:



Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth (MM/DD/YY) : ____/____/____ Social Security #: _____ Sex: Female Male

Address: _____ Apt/Lot # _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Mobile Home

Who can we contact in case of emergency or unable to reach you: Full Name: _____

Relationship: _____ Home Phone: _____ Cell Phone: _____

What is the best time to contact you? Anytime Morning Afternoon Evening

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

Patient Ethnicity

- Non-Hispanic
 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
 Samoan
 Asian Indian
 Chinese
 Filipino
 Japanese
 Korean
 Vietnamese
 Other Asian
 Don't Know/Decline

Parent or Guardian Information

Guarantor Name (Person to be billed):

Relationship to Patient: Mother Father Other guardian

DOB: _____ SSN: _____

Phone (check here if same as above) Address (check here if same as above)

Address (if different): _____

Mobile Phone Number: _____

Home Phone Number: _____

Preferred Contact Number: Mobile Home

Email Address: _____

Other Parent or Guardian:

Relationship to Patient: Mother Father Other guardian

DOB: _____ SSN: _____

Phone (check here if same as above) Address (check here if same as above)

Address (if different): _____

Mobile Phone Number: _____

Home Phone Number: _____

Preferred Contact Number: Mobile Home

Email Address: _____

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: _____



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

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

HIPAA Privacy and Release of Information

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

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 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: _____

Relationship to patient: _____