



## "Welcome to Good Samaritan Clinic"

In order to better serve you, we need the following information. We want to assure you that this information will be kept confidential.

### PATIENT INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Check One: ( ) Male ( ) Female      Check if Patient is under 18 ( )

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number(    ) \_\_\_\_\_ Message Number(    ) \_\_\_\_\_

Cell Phone Number(    ) \_\_\_\_\_

Marital Status \_\_\_ Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced

Name of Spouse \_\_\_\_\_

Number of People in Household \_\_\_\_\_ Estimated Annual Income\$ \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone(    ) \_\_\_\_\_

Relationship \_\_\_\_\_ List any type of Health Insurance \_\_\_\_\_

I have read the HIPPA Privacy Policies. I will allow the Good Samaritan Clinic to give information to the following person \_\_\_\_\_ Relationship to patient \_\_\_\_\_ about my medical treatment for certain reasons. These reasons include scheduling of appointments and medical consultations from the doctor, nurse or other medical personnel representing the Good Samaritan Clinic. I also give permission for the Good Samaritan staff to leave messages about my medical treatment on a message phone or answering machine.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

For Office Use Only    Fee Charge \_\_\_\_\_ %    Date last updated \_\_\_\_\_    W B HSP AS-PAC AM-1 FHH 62+ DIS

**MEDICAL RECORDS RELEASE/REQUEST FORM**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ State and Zip Code \_\_\_\_\_

Phone: (    ) \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(Check Both)

Release \_\_\_\_\_ Releasing information from GSC to you or your provider

Request \_\_\_\_\_ Requesting information from another provider to GSC

I authorize Good Samaritan Clinic to release/request the following:

Information Requested: \_\_\_\_\_

Purpose of Request: \_\_\_\_\_

\_\_\_\_\_

To/From – Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone and Fax: \_\_\_\_\_

- I understand that this authorization shall be valid as long as I am a patient with Good Samaritan Clinic, but that I may revoke it in writing at any time; any such revocation shall have no effect of disclosures made previously.
- I understand that I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
- I understand that the release of information may not be re-released to any other person or organization without my written consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed By \_\_\_\_\_ Date \_\_\_\_\_

**PART II**  
**PATIENT INFORMATION**  
**(OPTIONAL)**

If you would like for Good Samaritan Clinic to try to assist you in acquiring medications or provide medications if available, at no charge from pharmaceutical programs we need the following information:

(You will need to meet with our Financial Auditor to find out if you qualify for our Medication Assistance Program)

- Photo ID (Arkansas or Oklahoma)
- Last Year's Federal Income Tax form, both pages signed and dated. If you did not file you will need to sign a special IRS form that states that you did not file.
- You will need a "Medicaid Denial Letter" Must have proof you have applied.
- Paycheck stubs or any income for the past month for everyone who lives in the same house as you.
- Proof of AR/OK residence with your name and mailing address (Social Security, utility bill, etc.) Note: No Junk mail
- Proof of number of dependents (School ID, Social Security card, passport, birth certificate, etc.)
- Any of the following items that apply to you:
  1. Housing Assistance
  2. Proof of Food Stamps
  3. Most recent Social Security benefit statement and/or pension statement
  4. Letter stating that you have filed for Disability
  5. College class schedule
  6. Other information that could help prove that you meet the Medication Assistance Program criteria

"Applications must be returned in person by applicant unless a minor. We will not accept applications through the mail."

## FINANCIAL INFORMATION

### PATIENT EMPLOYMENT

Do you have a job? ( ) Yes ( ) No Employed: ( ) Full Time ( ) Part Time ( ) Self-employed ( ) Retired ( ) Disabled

Where do you work? (list "Self" if self-employed) \_\_\_\_\_

Occupation \_\_\_\_\_ How long have you worked there? \_\_\_\_\_

If self-employed, you must show proof of income with bank statements, check stubs, or receipt books and last year's tax return.

If you are not working now, have you worked during the past 90 days? ( ) Yes ( ) No

Do you have medical insurance, Medicare or Medicaid? ( ) Yes ( ) No

Is Health Insurance available through your Employer? ( ) Yes ( ) No

### SPOUSE'S EMPLOYMENT

Does someone who lives with you have a job? ( ) Yes ( ) No

Employed ( ) Full Time ( ) Part Time ( ) Self-Employed ( ) Retired ( ) Disabled

Where does your spouse work? (list "Self" if self-employed) \_\_\_\_\_

Occupation \_\_\_\_\_ How long have they worked there? \_\_\_\_\_

If self-employed, you must show proof of income with bank statements, check stubs, or receipt books and last year's tax return.

Is Health Insurance available through your Spouse's Employer? ( ) Yes ( ) No

How many people live in your home?

Number of Adults \_\_\_\_\_

Number of Children \_\_\_\_\_ (under age 18)

Total \_\_\_\_\_

### DEPENDENT INFORMATION

Dependent's Name (Supported by you)	Relationship (Spouse, Son, Daughter, etc.)	Date of Birth
_____	_____	___/___/___
_____	_____	___/___/___
_____	_____	___/___/___
_____	_____	___/___/___
_____	_____	___/___/___
_____	_____	___/___/___
_____	_____	___/___/___

U.S. Resident? \_\_\_ Yes \_\_\_ No Did you file an Income Tax Return last year? \_\_\_ Yes \_\_\_ No

Are you the Head of Household? \_\_\_ Yes \_\_\_ No