GOOD SAMARITAN CLINIC

# "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

615 North B Street • Fort Smith, AR 72901 • 479-783-0233

## 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