



Patient Demographic Form

PATIENT INFORMATION

Date of Birth

Female

Social Security Number

Sex ☐ Male ☐

Gender (Circle One)

Female

Male

Refused to Report

Genderqueer (Neither exclusively male nor female)

Other, please specify: _____

Male to Female/Transgender Female/Trans Woman

Female to Male/Transgender Male/ Trans Man

Marital Status (Circle One)

Married

Single

Divorced

Life Partner

Separated

Widowed

Other

Language if other than English:

Race (Circle One) Black-Non Hispanic

American Indian/Alaskan Native

Hispanic

Asian/Pacific Islander

White- Non Hispanic

Other

Ethnicity (Circle One) Not Hispanic/Latino

Another Hispanic, Latino/a, or Spanish Origin

Cuban

Puerto Rican

Mexican, Mexican American Chicano/a

Unreported/Refused to Report

Housing Status (Circle One)

Doubling Up

Homeless Shelter

Not Homeless

Other

Public Housing

Street

Transitional

Unknown

Home Address

Apt #

City

State

Zip Code

Home Phone

Work Phone

Cell Phone

Email Address

Employment Status (Circle One)

Disabled

Full-Time

Part-Time

None

Retired

Student

Unemployed

Veteran

Migrant or Seasonal Worker

ADDITIONAL INFORMATION

Have you recently been to the hospital for the same reason you are here today? ☐ Yes ☐ No

If yes, where and when?

Would you like text message appointment reminders? ☐ Yes ☐ No

Cell Phone Carrier



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PHARMACY INFORMATION

Pharmacy Name City State Zip Code

GUARANTOR INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency Contact) ☐ Spouse ☐ Parent ☐ Other

Last Name First Name Middle Initial

Date of Birth Social Security Number

Home Address Apt # City State Zip Code

Home Phone Work Phone Cell Phone

Employment Status (Circle One) Disabled Full-Time Part-Time None Retired
Student Unemployed Veteran Migrant or Seasonal Worker

CAREGIVER INFORMATION

Relationship to Patient ☐ Self (If self, skip to Insurance Information) ☐ Spouse ☐ Parent ☐ Other

Last Name First Name Phone Number

INSURANCE INFORMATION

Insured ☐ Yes ☐ No Insurance Name Policy Number Group Number

Policyholder's Name (First/Last) Policyholder's Date of Birth

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other Policyholder's Employer

Insurance Company Address Phone Number

Secondary Insurance Name Policy Number Group Number

Policyholder's Name (First/Last) Policyholder's Date of Birth

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other Policyholder's Employer

Insurance Company Address Phone Number

Staff Use Only

Updated/Verified: _____ Date: _____



PATIENT FINANCIAL OBLIGATION FORM

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I UNDERSTAND THE FOLLOWING:

- I am responsible for any charges that are incurred during my office visit.
- If I have insurance, I am responsible for co-pays, deductibles and co-insurance.
- If I fail to meet my financial obligations, my account will be sent to a collection agency after 90 days.
- I will have an opportunity to pay on this account before it will be sent to collections.
- I will receive 3 statements before my account will be turned over to collections.
- If I overpay and have a credit, the credit will be applied to other open claim balances. If no open claim balance exists and I have been turned over to a collection agency in the past, an in-house credit will be provided and issuance of a refund check will be deferred for one year.
- A payment plan is available at my request for unpaid balances before going to collections.
- Should I be unable to make a payment on my account at this time, I understand that the clinic will see me regardless of my ability to pay.

The organization's discounted fee program has been explained to me.

I do ☐ OR do not ☐ wish to participate in this program.

DISCLAIMER

I understand, acknowledge, and agree that to collect any money that I owe to the facility:

- I may be contacted by telephone or text message to any phone number that I give or is included on my account (including cell phone numbers that can result in charges on my phone account).
- ARcare/KentuckyCare/MississippiCare, or any other collection or servicing agency operating on behalf of the organization may contact me with auto dialing devices, pre-recorded messages, or voice mail messages.
- ARcare/KentuckyCare/MississippiCare, or any other collection or servicing agency operating on behalf of the organization may contact me using any e-mail address I provide to the organization or that is included on my account.

I understand the collection policy as explained above.

Patient OR Guarantor Signature

Date

Print Patient Name

Date of Birth

Patient OR Guarantor Mailing Address: _____

Staff Witness Signature

Date



HIPAA PRIVACY PRACTICES CONSENT FORM

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We are committed to providing security for patient privacy and confidentiality. We collect, use, and disclose personal health information only when allowed by state and federal laws and your personal authorization. This may include the collection of other sources of information available, such as medication and prescription history and verification of insurance eligibility.

We also understand you may have family members or significant people in your life who you may want to have access to certain information contained in your medical record. Without your written consent, we cannot release any information to anyone except for purposes outlined in the HIPAA privacy act. **Please note that we use an automated phone system to remind you of appointments as well as offer patients the opportunity to complete a survey about their visit.**

I give permission for those (employees, students, volunteers, contractors, etc.) acting on behalf of the organization to share my protected health information (PHI) with the following specific person(s): *(If no other person is authorized to receive your PHI, write N/A in the spaces below.)*

<i>Name of Individual to which information can be released</i>	<i>Information to be released (Enter corresponding # from list)</i>

Information to be released:

- [1] Copy of complete health record
- [2] History and physical
- [3] Test results
- [4] Mental health records
- [5] Reproductive health records
- [6] Other

If 12-17 years of age, patient must sign here to acknowledge approval of information to be released.

****I understand that I can revoke this release of medical information at any time by completing a new form.**

I give my permission to: **(INITIAL all that apply) MUST INITIAL AT LEAST ONE**

- [] Leave a message on my answering machine or other electronic device(s) about my appointments, lab results, follow-up care, or other medical information
- [] Contact me at my home address and phone number.
- [] Leave a message with the person indicated as a "message" number if I cannot be reached otherwise.
- [] Send me an email message at: _____
- [] Contact me regarding voluntary participation in a clinical research. I understand that by checking this box I am NOT obligated to participate in any specific project. Please contact me about projects by:
[] mail [] phone [] email address:
- [] I have received a copy of the Notice of Privacy Practices.

Print Name of PATIENT

Date of Birth

Signature of Patient OR Guardian

Date



CONSENT TO TREATMENT

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I give permission for ARcare/KentuckyCare/MississippiCare to give _____
medical treatment. Patient's Name

Date of Birth: _____ SSN: _____

Initial ONE:

- ☐ I am the patient.
☐ Patient is a minor who is _____ years of age.
☐ Patient is an adult who cannot act on his or her own.

If Patient is a minor:

I give permission for my child to receive an examination and treatment in the absence of adult supervision.

☐ Yes ☐ No

I give permission for the following individuals (other than parent/legal guardian) to bring my child to the clinic on my behalf (**Select at least ONE**):

☐ None ☐ School staff ☐ Clinic staff ☐ Daycare staff ☐ Other (please list)

Emergency Contact	Relationship	Phone Number

1. I voluntarily consent to medical care recommended by the medical provider including, x-rays, heart tracings, medications, and/or routine laboratory testing (including human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease if ordered by a clinician for diagnostic purposes).
2. I authorize the clinic to release medical information to insurance carriers for the purposes of filing insurance claims related to my/his/her medical care.
3. I agree that insurance (if applicable) will billed for services and I (patient, parent or guardian of the patient) am responsible for any charges not paid or denied by the insurance company.
4. I understand that even if you have a copy of my Advance Directive or Living Will that clinic staff will attempt to stabilize me and transfer me to an acute care hospital for further evaluation and treatment.
5. This form has been fully explained to me and I understand its contents.

COMMENTS: _____

Signature of patient or adult consenting for patient Relationship to Patient Date

Signature of staff who explained the contents of this consent form Date



HOUSEHOLD ASSESSMENT

(ONLY for patients requesting discounted services)

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ARcare/ KentuckyCare /MississippiCare offer a discounted fee program (nominal/sliding fee discount) to eligible patients who apply for assistance. The discounts are based on the Federal Poverty Guidelines. Discounts are given up to 199% of the Federal Poverty Level. Income verification must be provided before discounts will be applied. Discounts will not be given to households above 200% of the Federal Poverty Level.

Is Patient head of Household? ☐ yes ☐ no

If no, who is the head of Household? _____

List all dependents (anyone who resides with you and for whom you have legal, custodial, or financial responsibility. Please list the total monthly gross income for each household member.

<i>Name</i>	<i>Relation to Patient</i>	<i>Birth Date</i>	<i>Income</i>
	<i>self</i>		

By signing this application, I represent that the information and answers given in this application are true, complete and correctly recorded. If fraudulent misstatements were made, the organization reserves the right to request full payment for services provided to the patient. I understand that any charges for my household that are not covered by the discounted service program are my responsibility for my household and I agree to pay for these charges

Signature _____

Date _____

For office use only: Show your calculations

Total Annual Income: _____ Total of Household Members Qualified: _____

Eligible for Sliding Fee Discount Program Level: (Circle one)

MEDICAL: [A -\$30] [B - 20%] [C - 40%] [D - 60%] [E - 80%] [F- 95%] [G - 100%]

DENTAL: [A -\$60] [B -40%] [C -30%] [D -20%] [E - 10%] [F- 5%] [G- 100%]

EFFECTIVE DATE: _____ EXPIRATION DATE: _____

Reviewed by: _____

Date: _____