Atchison Community Health Clinic

NEW PATIENT INFORMATION			
Last Name (Legal):	**First Name (Legal):**	**MI:**	**Preferred Name:**

Date of Birth:	**Sex Assigned at Birth:** □ Male □ Female	**Gender Identity:** □ Male □ Female □ Transgender Male (F to M) □ Transgender Female (M to F) □ Something else □ Choose not to disclose	**Sexual Orientation:** *Romantic and/or sexual attraction a person feels for another person.* □ Heterosexual (straight) □ Lesbian or Gay □ Bisexual □ Something Else □ Don't know □ Choose not to disclose
Home Phone #: ☐ Permission to leave voicemail	**Cell Phone #:** ☐ Permission to leave voicemail		
Appointment Confirmation Preference: □ Phone Call □ Text Message *appointments are required to be confirmed through reminder calls/texts*			

Address:	**City:**	**State:**	**Zip:**

Email Address:

*Your email will be used to sign you up for the **patient portal**. This allows you to message your care team, see visit notes, and lab results, etc.*

Social Security #:	**Ethnicity:** □ Hispanic/Latino □ Not Hispanic	**Race:** □ Alaska Native □ American Indian □ Asian □ Black / African American □ Native Hawaiian □ Pacific Islander □ White / Caucasian	**Are you homeless?** □ Yes □ No **If yes, please select one:** □ Shelter □ Street □ Transitional □ Unknown □ Doubling up (couch surfing, etc.) □ Other
Marital Status: □ Single □ Married □ Widowed □ Partner □ Divorced □ Separated	**Language:** □ English □ Spanish □ Other (please specify):		
Are you a migrant worker? □ Yes □ No	**Are you a U.S. Veteran?** □ Yes □ No	**Patient Employment Status?** □ Full Time □ Part Time □ Unemployed □ Retired □ Self Employed □ Active Military	
Patient Employer Name:	**Employer Phone:**	**Employer Address:**	

PARENT/GUARDIAN INFORMATION (for minors under the age of 18)		
Last Name:	**First Name:**	**MI:**

Social Security #:	**Phone Number:**	**Date of Birth:**
Email Address:		

EMERGENCY CONTACT		
Name:	**Relationship to Patient:**	**Phone:**

Signature:_____ Relationship to Patient:_____Date:_____

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KANSAS MEDICAID BENEFITS	
Do you have KanCare? ☐ YES ☐ NO	☐ Kansas Medicaid ☐ Sunflower ☐ United Healthcare ☐ Aetna
KanCare policy ID #:	

PRIMARY INSURANCE INFORMATION		
Primary Insurance Company:	**Primary Insurance Address:**	
Subscriber First and Last Name:	**Subscriber date of birth:**	**Subscriber Social Security Number:**
Insured Relationship to Patient: ☐ Self ☐ Patient is the spouse of insured ☐ Natural Child ☐ Step Child ☐ Parent ☐ Other ☐ Grandparent ☐ Foster Child		

SECONDARY INSURANCE INFORMATION		
Secondary Insurance Company:	**Secondary Insurance Address:**	
Subscriber First and Last Name:	**Subscriber date of birth:**	**Subscriber Social Security Number:**
Insured Relationship to Patient: ☐ Self ☐ Patient is the spouse of insured ☐ Natural Child ☐ Step Child ☐ Parent ☐ Other ☐ Grandparent ☐ Foster Child		

DENTAL INSURANCE		
Primary Insurance Company:	**Primary Insurance Address:**	
Subscriber First and Last Name:	**Subscriber date of birth:**	**Subscriber Social Security Number:**
Insured Relationship to Patient: ☐ Self ☐ Patient is the spouse of insured ☐ Natural Child ☐ Step Child ☐ Parent ☐ Other ☐ Grandparent ☐ Foster Child		

Atchison Community Health Clinic

Consent

I hereby give consent for the clinic to leave telephone messages regarding my appointment dates and times.

I here by give consent for the clinic to send text messages regarding my appointment dates and times.

I understand that the Atchison Community Health Clinic is not responsible for any bills incurred outside its services such as ambulance, emergency room visits, outpatient or inpatient hospital care, diagnostic tests (x-rays, lab, etc.), specialist referrals, ongoing medications or medical supplies

If I am unable to keep a referral appointment, I am required to cancel the appointment with the doctor's office or hospital prior to the appointment time.

All information provided within this packet is correct and current as of this date.

I herby give consent to the provider to view my prescription history from other services.

I herby authorize the provider to furnish my insurance company all information which the insurance company requests concerning my present illness/injury. I, hereby assign to the provider all money to which I am entitled for medical and/or surgery expense relative to the services, but not to execute indebtedness to the provider/surgeon. It is understood that any money received from my insurance company over and above any money owed to ACHC is to be refunded to me when my bill is paid in full. I understand I am responsible to the provider(s) for charges not covered by this assignment. Charges shown by statements are assumed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event action should become necessary to collect unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fee or other such costs as the court determines proper. It is agreed that payment will not be delayed or withheld because of insurance coverage of the pendecy of claims thereon. All proceeds of insurance are assigned to this office where applicable. We are an equal opporunity provider.

I give permission for evaluation and treatment for myself, or a minor child, by personnel employed by the Atchison Community Health Clinic, or volunteers of the clinic.

I understand that Telehealth is a service option available at Atchison Community Health Clinic. Telehealth is the delivery of services using interactive technologies (audio, video or other electronic communications) between a provider and a client that are not in the same physical location. The interactive technologies used in Telehealth incorporate network and software security protocols to protect the confidentiality of patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

I understand that I have the right to refuse any specific diagnosis or treatment service without jeopardizing my right to receive health services at the Clinic, but I also understand that certain medications will not be prescribed because of this refusal. I understand that health services are not based on an exact science, and I acknowledge that no guarantees have been made to me as to the results of any treatment services.

I understand that the Atchison Community Health Clinic does not provide emergency care or chronic pain management.

I understand that if I am unable to keep my appointment, I must give the clinic 24 hours advance notice or I will

be marked as a no show. I understand after two consecutive no shows or three no shows in 90 days, I will be required to speak to the case manager before scheduling a new appointment.

I understand that all files are kept confidential in their use by the Atchison Community Health Clinic staff and that my written consent is required for any release of information by the Atchison Community Health Clinic to other persons or agencies, except as required by law in cases of court orders, child abuse, life threatening situations, national security issues, and to the Atchison Hospital for the purpose of uncompensated care. In court ordered evaluations, any and all relevant information, including previously obtained material, may be realeased to the court.. The staff is required by law to report any suspicion of child, elder or vulnerable person abuse, including neglect, emotional, physical or sexual abuse.

My financial or statistical information may be released to funding sources which directly benefit me or assist the Atchison Community Health Clinic in providing services.

In an apparent life-threatening situation, I, or my minor child above will be taken to a hospital emergency room by ambulance. Payment for ambulance services, emergency services and emergency room care will be my responsibility.

I acknowledge that some medication provided by the Clinic may not be in childproof containers. As such, I accept the responsibility for maintaining this medication in a safe and secure location.

I may be referred to a specialist for consultation. The clinic is not responsible for charges incurred from specialist. A referral is for one office visit only. Payment for test or procedures ordered by a specialist is my responsibility, therefore, I will discuss such payment with the specialist in advance. I understand I should not expect the specialist to provide ongoing help unless I am willing to pay for it.

For any lab or sample sent to an outside lab, there will be an additional charge.

I have read the “Consent for Treatment and Policies of the Atchison Community Health Clinic” stated above. I understand them or have had someone clarify to me anything I did not understand. I agree to the terms and conditions stated in the Consent and Consent to Treatment and Policies of Atchison Community Health Clinic.

My signature on this form signifies that I have read and understand the above information.

Printed Name: _____ **DOB**:_____

Signature: _____**Date**:_____

Atchison Community Health Clinic

Acknowledgement of Receipt of Revised Notice of Privacy Practices

I acknowledge that I have received a copy of the Atchison Community Health Clinic's Notice of Privacy Practices.

Signature: _____ **Date**:_____

Printed Name: _____

Relationship to patient: _____

Signature of Employee Witness:_____ **Date**:_____

Documentation of Good Faith Efforts

Patient Name: _____ **Date**:_____

The patient presented to the facility on this date and was provided with a copy of the Atchison Community Health Clinic's Notice of Privacy Practices. A good faith effort was made to obtain from the patient (or the patient's representative) a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

◯ **Patient/Patient Representative refused to sign.**
◯ **Patient/Patient Representative was unable to sign because:**
_____

◯ **Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.**
◯ **Other reason:** _____
_____

Signature of Employee Completing Form: _____