DELHI COMMUNITY HEALTH CENTER

PATIENT INFORMATION

Date: ____/_____/_____ Pharmacy _____

Doctor or (Referring Dr.) _____

Last Name _____ First Name _____ MI _____ Jr. Sr. III

Mailing Address _____

Address City State Zip

Physical Address _____

Date of Birth _____ SSN _____ - _____ - _____ E-Mail _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Consent to receive Calls ❒ Yes ❒ N **Consent to receive Text** ❒ Yes ❒ No

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*** Children under 18 years of age must be accompanied by an adult***

Guardian: Last Name _____ First Name _____

Address _____ City _____ Zip Code _____

Date of Birth _____ SSN _____ - _____ - _____ E-Mail _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

School _____ Grade _____

Insurance Information

Company Name: _____

Policy or Card #: _____

Policy Holder's Last Name: _____ First Name: _____

Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's SSN#: _____ - _____ - _____

Policy Holder's Address: _____ City: _____ Zip Code: _____

If Medicaid, PCP (Referring Dr.) _____

Company Name: _____

Policy or Card #: _____

Policy Holder's Last Name: _____ First Name: _____

Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's SSN#: _____ - _____ - _____

Policy Holder's Address: _____ City: _____ Zip Code: _____

If Medicaid, PCP (Referring Dr.) _____

Are you a veteran of the military? *(Check one)* ❒ Yes ❒ No

Gender Identity (*Check one*) ❒ Male ❒ Female ❒ Transgender Male/Male to Female ❒ Gender queer ❒ Transgender Female/Female to Male ❒ Choose Not to Disclose ❒ Other _____

Sexual Orientation (*Check one*) ❒ Lesbian, Gay or Homosexual ❒ Straight or Heterosexual ❒ Bisexual ❒ Something Else ❒ Don't Know ❒ Choose Not Disclose

Race *(Check one)* ❒ White ❒ Black ❒ Hispanic ❒ Asian ❒ American Indian ❒ Pacific Islander ❒ Other

Ethnicity (*Check one*) ❒ Hispanic ❒ Non-Hispanic

What is your marital status? *(Check one)* ❒ Single ❒ Married ❒ Separated/Divorced ❒ Widowed

Housing Status (*Check one*) ❒ Homeless ❒ Doubled Up ❒ Street ❒ Transitional ❒ N/A

Where do you usually receive your health care? *(Check one)*

❒ Emergency Room ❒ Clinic or Hospital ❒ Private Doctor ❒ Haven't received healthcare in _____ years

Who can we contact in case of emergency?

Last Name _____ First Name _____

Address _____ Phone Number _____ Relationship to you _____

How many people live in your household? _____ *List their names, birth dates, income & SSN if available*

NAME	DATE OF BIRTH	SOCIAL SECURITY #	INCOME

Are you currently employed? *(Check one)* ❒ Yes ❒ No

Place of employment: _____ **Phone Number:** _____

Are you an Agricultural Worker? *(Check one)* ❒ Yes ❒ No

What is your gross annual income? _____ *(Attach copies of latest check stubs)*

DELHI COMMUNITY HEALTH CLINIC

Baseline Information

Are you receiving any one of the following benefits? (We must have copies of any that are marked yes. Without proof of income, you will not receive a discounted price.)

	YES	NO	If so, how much?
Medical Assistance	☐	☐	_____
State Public Assistance	☐	☐	_____
SSI / SSDI	☐	☐	_____
Social Security	☐	☐	_____
Veterans Retirement/Disability	☐	☐	_____
Workers Compensation	☐	☐	_____
Unemployment	☐	☐	_____

Annual Income in your household

- ☐ $10,000 - 20,000
- ☐ $21,000 - 35,000
- ☐ $36,000 - 40,000
- ☐ $41,000 - 50,000
- ☐ $51,000 +

I certify that I have read or had read to me the above questionnaire and that all of the information is correct. I understand that failure to make full disclosure of my true gross income is considered an act of fraud and can be punishable by either a fine or imprisonment according to federal law.

TO RETAIN SLIDING FEE SCALE PRIVILEGES PROOF OF INCOME MUST BE SUPPLIED WITHIN 5 DAYS OF THIS APPLICATION.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS ON MY BEHALF OR AS NECESSARY TO FACILITATE MY CARE OR THE CARE OR THE CARE OF MY MINOR CHILD. I AGREE TO BE FULLY RESPONSIBLE FOR ALL LAWFUL DEBTS INCURRED BY MYSELF OR MY MINOR CHILD FOR SERVICES RECEIVED AT THE DELHI COMMUNITY HEALTH CLINIC.

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PATIENT'S OR GUARDIAN SIGNATURE DATE

**** Delhi Community Health Center is a federally qualified health Center*

Delhi Community Health Center
Delhi, LA

Delhi Community Health Center

109 Elm Street, Delhi, Louisiana 71232 \ (318) 878-6650

DCHC CONSENT FOR TREATMENT

CONSENT FOR TREATMENT

I authorize Delhi Community Health Center and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, as they determine necessary for an annual year. I understand that my condition may call for a consultation with another Healthcare Provider. If this situation occurs, I authorize DCHC to release any medical information that may be needed to better provide for my medical treatment.

ASSIGNMENT AND RELEASE OF BENEFITS

☐ PRIVATE INSURANCE: I certify that I and/or my dependents have insurance coverage and assign directly to Delhi Community Health Center all insurance benefits otherwise payable to me for services rendered. I understand I am responsible for all charges not paid by insurance. I authorize the use of my signature on all insurance submissions. The above physician/clinic may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services rendered.

☐ MEDICARE, MEDICAID, MEDIGAP: I request that payment of the authorized benefits be made either to me or on my behalf to Delhi Community Health Center for any services furnished by this provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, Medigap insurer, and their agents any information needed to determine these benefits for related services.

FINANCIAL AGREEMENT:

The undersigned understands and agrees that regardless of the patient's assigned insurance benefits the patient or responsible party is responsible for the total charges for services rendered, except for Medicare patients as set forth below, and further agrees that all amounts are due upon request and are payable to Delhi Community Health Center. The undersigned further understands that should this account become delinquent and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, the patient, as the designated responsible party, shall pay the reasonable attorney fees for collection expense.

NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the NOTICE OF PRIVACY PRACTICES for Delhi Community Health Center and its' entities. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that Delhi Community Health Center and its' entities may not be required to agree to the restrictions requested.

GENERAL OFFICE POLICIES

1. All co-pays and deductible amounts must be paid at the time of service.
2. All returned checks are subject to a service charge.
3. All delinquent accounts are automatically turned over to collection after 120 days if no response of payment is received.
4. All patients will be seen on a first come first serve basis, although Delhi Community Health Center has the right to take patients with medical emergencies first.
5. This is a "SMOKE FREE" building. All smoking is prohibited.
6. No alcohol or drug use is allowed on the premises. Anyone abusing this policy will be asked to vacate the premises. If this request is not followed, Law Enforcement will be called.

My signature below indicates acknowledgement of receipt of the above information including (when applicable) a detailed NOTICE OF PRIVACY PRACTICES.

Patient/Patient Representative Signature

Witness Signature

Date:_____