IBERIA COMPREHENSIVE COMMUNITY HEALTH CENTER
PATIENT PROFILE

○ Iberia	○ Surrey
○ Abbeville	○ Surrey Peds
○ Many	○ Merryville
○ St. Martin	

PATIENT INFORMATION

Patient's last name:	First:	Middle:

Birthdate:	Social Security Number:	Home Phone:	Cell Phone:	Email Address:

Address:

RACE/OTHER INFO

□Black/African American □ White □ More than One Race □ Asian □ Native Hawaiian

□ Other Pacific Islander □ American Indian/Alaskan □ Unreported/Refused to report

Veteran? □ Yes □ No Homeless? □ Yes □ No Seasonal/Migrant Worker? □ Yes □ No Language Other than English? □ Yes □ No

EMPLOYMENT AND INCOME

Range of Income per year (please check one below) **Number of people in household:**

	$0-$12,000		$21,001-$24,000		$32,001-$36,000
	$12,001-$16,000		$24,001-$28,000		$36,001-$40,000
	$16,001-$20,000		$28,001-$32,000		OVER $40,000

INSURANCE INFORMATION

Primary insurance □ Yes □ No: **Insurance Company Name:**

Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group #:	Policy #:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Emergency Contact Name:	Relationship to patient:	Phone #1:	Phone #2:

SEXUAL ORIENTATION AND GENDER

Note: Collection of this information is a requirement for Community Health Centers in our Federal reporting. NO names are attached to collection of this data, only the number of patients will be reported. If you do not wish to answer, please use the "Choose not to disclose" option.

PATIENT'S GENDER IDENTITY (PLEASE CHECK ONE)	PATIENT'S SEXUAL ORIENTATION (PLEASE CHECK ONE)
□ Male	□ Straight (not lesbian or gay)
□ Female	□ Lesbian or Gay
□ Transgender Male (Female to Male)	□ Bisexual
□ Transgender Female (Male to Female)	□ Something Else
□ Other	□ Don't know
□ Choose not to disclose	□ Choose not to disclose

SIGNATURE

SIGNATURE: **DATE:**

Interviewer comments/signature_____Date:_____

GENERAL CONSENT:

1. I, the undersigned, grant permission for myself to undergo the usual tests, treatment and other procedures required in the course of study, diagnosis, and treatment for illness by the staff of Iberia Comprehensive Community Health Center (ICCHC).
2. I am aware that the practice of medicine and dental medicine is not an exact science, and I acknowledge that no guarantees of a cure have been made to me as a result of examinations or treatments by ICCHC.
3. I give permission to release to the insurance company medical information necessary in the filing of lawful claims by ICCHC, staff or services rendered by them for myself or my dependents.
4. I consent to the release of information for audit purposes to third party payers, prescription assistance programs and government agencies.
5. I hereby authorize payment directly to ICCHC of benefits due to me in my pending claim(s) and/or Major /Medical Benefits otherwise payable to me, not to exceed ICCHC's or the physician's regular charges for this service.
6. I certify that the information given by me in applying for payment under Title XVII of the SSA Act is correct. I authorize any holder of medical or other information intermediaries or carriers or any other insurer any information needed for this or any related Medicare/Medicaid Claims. I request benefits be made on my behalf.
7. I understand the fee policies of ICCHC and my obligations to pay medical expenses under this policy.
8. I agree that this form shall be valid for one (1) year.
9. I agree that a Photostat copy of this form is as valid as the original for the period stated.
10. I understand and agree that dental X-Rays are to remain at ICCHC.
11. I certify that the above is true and accurate to the best of my knowledge and changes in insurance status or income which effects reduced or discounted services including free prescription programs will be reported to ICCHC. I understand that I may be prosecuted if I provide false information and receive discounted benefits.

_____ _____

Patient (Print Name) Signature

MINOR CONSENT:

I ATTEST THAT I HAVE REVIEWED THE ABOVE AND AM AWARE OF ITS CONTENTS.

Note: If the patient is a minor, the parent, guardian, relative or person temporarily standing in loco parentis, any consent for the minor under his care. Print the name of the minor on the first line. Print and sign the name of parents, guardian, relative or loco parentis on the second line. Address and phone number is also required.

BY _____ **_____**

Print Name of Person giving consent **Relationship to Patient**

_____ **_____**

Signature of Person giving consent **Telephone Number**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____have received the Notice of Privacy Practices from Iberia Comprehensive Community Health Center.

X_____ Date: _____

In lieu of patient signature, I _____, a staff member of Iberia Comprehensive Community Health Center, state that _____has been given our current Notice of Privacy Practices.

X_____ Date: _____

PATIENT RIGHTS & RESPONSIBILITIES

I have read and fully understand the rights and responsibilities as an ICCHC patient. A copy of this signed document will be placed in your medical record.

_____ _____

Patient Signature Date

Interviewer's Signature _____ **Date**_____