IBERIA COMPREHENSIVE COMMUNITY HEALTH CENTER, INC.

PATIENT PROFILE

☐ Abbeville ☐ Iberia ☐ Deridder ☐ Merryville ☐ Many
☐ St. Martin ☐ Surrey ☐ Surrey Peds ☐ Vernon ☐ Vision Center

Date: _____

Patient Name			
Birth Date		**Sex: ☐ Male ☐ Female**	**Social Sec. #**

Address/Phone Number

Street			
City		**State:**	**Zip:**
Phone Number:	**Home:**	**Work:**	
E-Mail Address:		**Pharmacy:**	
Emergency Contact Name:		**Relationship:**	**Phone:**
Who can we discuss and/or release your health care information to:			**Phone:**

INSURANCE INFORMATION

Insurance □ Yes □ No: **Insurance Company Name: _____**

Subscriber's name:	**Subscriber's S.S. #:**	**Birth date:**	**Group #:**	**Policy #:**
Patient's relationship to subscriber:				

Note: Collection of the following 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 SEXUAL ORIENTATION (PLEASE CHECK ONE)

□ Straight (not lesbian or gay) □ Lesbian or Gay □ Bisexual □ Other □ Don't know □ Choose not to disclose

PATIENT'S GENDER IDENTITY (PLEASE CHECK ONE)

□ Male □ Female □ Transgender Male (Female to Male) □ Transgender Female (Male to Female) □ Other □ Choose not to disclose

RACE (PLEASE CHECK ALL THAT APPLY)

□ Black/African American □ White □ Asian Indian □ Chinese □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian □ Samoan

□ Native Hawaiian □ Other Pacific Islander □ Guamania\Or Chamorro □ American Indian/Alaskan □ Other_____ □ Declined to Specify

ETHNICITY (PLEASE CHECK ONE) □ Mexican □ Mexican American □ Chicano □ Puerto Rican □ Cuban
□ Hispanic/Latino or Spanish Origin □ Non-Hispanic/Latino or Spanish Origin □ Choose not to disclose

LANGUAGE (PLEASE CHECK ONE) □ English □ Spanish □ Laotian □ Other:_____

ADDITIONAL INFORMATION (CHECK ALL THAT APPLY)

□ Veteran □ Migratory Agricultural Worker □ Seasonal Agricultural Worker

IF HOMELESS (CHECK ONE) □ Street □ Shelter □ Doubling □ Transitional □ Permanent Supportive Housing

FAMILY INCOME

Number of people in household: _____

Range of Income per year (please check one below)

□	**$0-$15,060**	□	**$18,073-$19,578**	□	**$22,591-$24,096**	□	**$27,109-$30,120**
□	**$15,061-$16,566**	□	**$19,579 -$21,084**	□	**$24,097-$25,602**	□	**Over $30,121**
□	**$16,567-$18,072**	□	**$21,805-$22,590**	□	**$25,603-$27,108**		

(OVER)

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 payors, 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 am aware that the PCMH model provides care for the whole person through better access, a dedicated personal provider/team and care that is coordinated across the entire health care system, with the goal of maximizing health outcomes.
11. I agree that a Photostat copy of this form is as valid as the original for the period stated.
12. I understand and agree that dental X-Rays are to remain at ICCHC.
13. 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.
14. Consent to share data with other entities.
15. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**
16. I have read and fully understand the rights and responsibilities as an ICCHC patient.

_____ _____

Patient (Print Name) **Signature**

Date _____

IF PATIENT IS A MINOR - COMPLETE MINOR CONSENT BELOW:

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, may consent for the minor under their 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.

_____

Patient (MINOR)

For Legal Minors:

BY _____ _____

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

_____ _____

Signature of Person giving consent **Telephone Number**

Interviewer Initials: _____

Date: _____