Health Partners Free Clinic

PATIENT DEMOGRAPHIC/CONSENT FOR TREATMENT/HIPAA AUTHORIZATION/RELEASE

First Name	Middle Initial	Last Name	DOB
Address	City & State		Zip Code
Home Phone Number	Mobile Phone Number		Social Security Number
Email Address	Are you a Veteran? ☐ Yes ☐ No		Employed? ☐ Yes ☐ No
Name of Employer		Employer Phone	
Insured? ☐ Yes ☐ No	If yes, do you have: ☐ Medicaid ☐ Medicare ☐ Insurance Card	Marital Status	Ethnicity
# in your household	Sex	Race	Language

Can we share information about your general medical condition or appointments with your work or school? ☐ Yes or ☐ No

If yes, please list work or school phone number_____

I have access to the Privacy Notice. ☐ Yes or ☐ No

I give authority to obtain my medication history. ☐ Yes or ☐ No

Can messages be left on your home answering machine or voicemail? ☐ Yes or ☐ No

Do you have an alternate phone number where we can leave messages? ☐ Yes or ☐ No

If yes, please list the phone number(s)_____

Please list family members or other persons that we can talk to about your general medical condition, diagnosis, appointments, lab and x-ray results, or other health care information.

_____

IN AN EMERGENCY WE MAY CONTACT

Name_____Relationship_____Phone # (s)_____

HIPAA AUTHORIZATION

I, the Patient or Representative, have been shown the HIPAA AUTHORIZATION FOR TEXT, EMAIL & VOICE MESSAGING. By signing below, I confirm that I have read the form, understand and accept its contents, and know that a I have a right to receive a copy of the form for my records.

Do you want to participate in the TEXT, EMAIL & VOICE MESSAGING Program? ☐ Yes or ☐ No

CONSENT FOR TREATMENT

I hereby acknowledge and understand that by signing below, I am giving informed consent to the provisions of diagnosis, care and/or treatment by Health Partners Free Clinic, and cannot bring a tort or other similar action including an action on a medical or other health-related claim, against Health Partners Free Clinic unless the action or omission of Health Partners Free Clinic constitutes willful or wanton misconduct.

_____ _____ _____

Print patient name or representative/guardian name | Patient or representative/guardian Signature | Date