615 North B Street
Fort Smith, Arkansas 72901
Phone: 479-783-0233
Fax: 479-494-7248

Providing compassionate healthcare to the medically undeserved

PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Check One: ☐ Male ☐ Female Race: _____ Are you insured? ☐ YES ☐ NO

Are you insured through : ☐ MEDICAID ☐ MEDICARE ☐ OTHER

Please Explain: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Primary Phone #: _____ Message Phone #: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name of Spouse: _____ Number in Household: _____

Estimated Annual Income: $ _____ Emergency Contact: _____

Relationship: _____ Emergency Contact Phone #: _____

How did you hear about us? _____

I have read the HIPAA Privacy Policies. I will allow the Good Samaritan Clinic to give information to the following person _____ relationship to patient _____ about medical treatment for certain reasons. These reasons include scheduling of appointments and medical consultations from the doctor, nurse, or other medical personnel representing the Good Samaritan Clinic. I also give permission for the Good Samaritan staff to leave messages about my medical treatment on a message phone or answering machine.

_____ _____

Signature of Patient or Legal Guardian Date

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MEDICAL RECORDS RELEASE/REQUEST FORM

(Check One)
Release _____ Releasing information from us to you or your provider
Request_____ Requesting information from another provider to us

Date: _____

Name: _____ Date of Birth: _____

Address: _____

State & Zip Code: _____ Phone Number: _____

Social Security #: _____ - _____ - _____

I authorize Good Samaritan Clinic to release/request (circle one) the following:

Information Requested: _____

Purpose of Request: _____

Duration of Authorization: _____

To/From (circle one) Name: _____

Address: _____

Phone Number: _____ Fax Number: _____
(It is important that you give as much contact information as possible, especially the provider's name and phone number)

- I understand that this authorization shall be valid through _____ (date), but that I may revoke it in writing at any time' any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me
- I understand that the release of information may not be re-released to any other person or organization without my written consent

Signature: _____ Date: _____

Witnessed by: _____Date: _____

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PATIENT INFORMATION (PART II)

If you would like for Good Samaritan Clinic to try to assist you in acquiring medications or provide medications if available, at no charge from pharmaceutical programs we need the following information:

(You will need to meet with our Financial Auditor to find out if you qualify for our Medication Assistance Program)

- Photo ID (Arkansas or Oklahoma)
- Last years Federal Income Tax Form, both pages signed and dated. If you did not file you will need to sign a special IRS form that states that you did not file.
- You will need a "Medicaid Denial Letter." Must have proof that you applied.
- Paycheck stubs or any income from the past month for everyone who lives in the same house as you.
- Proof of AR/OK residence with your name and mailing address (social security, utility bill, etc.) Note: No Junk mail
- Proof of number of dependents (school ID, social security card, passport, birth certificate, etc.)
- Any of the following items that apply to you:
    - Housing Assistance
    - Proof of Food Stamps
    - Most recent Social Security benefits statement and/or pension statement
    - Letter stating that you have filed for disability
    - College class schedule
    - Other information that could help prove that you meet the Medication Assistance
    - Program criteria

Applications must be returned in person by application unless a minor.
We will not accept applications through the mail.

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FINANCIAL INFORMATION

PATIENT EMPLOYMENT

Do you have a job? ☐ YES ☐ NO

Employed: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Disabled

Where do you work? (list "self" if self-employed) _____

Occupation_____ How long have you worked there? _____
(If self-employed, you must show proof of income with bank statements, check stubs, or receipt books and last year's tax return.)

If you are not working now, have you worked during the past 90 days? ☐ YES ☐ NO

Do you have media insurance, Medicare or Medicaid? ☐ YES ☐ NO

Is health insurance available through your employer? ☐ YES ☐ NO

SPOUSE'S EMPLOYMENT

Does someone who lives with you have a job? ☐ YES ☐ NO

Employed: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Disabled

Where does your spouse work? (list "self" if self-employed) _____

Occupation _____ How long have they worked there? _____
If self-employed, you must show proof of income with bank statements, check stubs, or receipt books and last year's tax return.

Is health insurance available through your spouse's employer? ☐ YES ☐ NO

How many people live in your home?

Number of adults _____

Number of children _____ (under age 18)

Total _____

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DEPENDENT INFORMATION

Dependent's Name (Supported by you)	Relationship (Spouse, Son, Daughter, etc.)	Date of Birth

U.S. Resident? ☐ YES ☐ NO Did you file an Income Tax Return last year? ☐ YES ☐ NO

Are you the Head of Household? ☐YES ☐NO

Did you receive Social Security or Disability Income? ☐ YES ☐NO

Date Applied _____ Date Approved _____ Date Denied _____

Monthly Social Security Income $ _____
Does your spouse or child receive Social Security, Medicare, or Disability income? ☐YES ☐NO

TOTAL HOUSEHOLD INCOME

Household Income	Patient	Others		Patient	Others
Salary/Wages	$_____	$_____	Retirement	$_____	$_____
Alimony	$_____	$_____	Pension	$_____	$_____
Child Support	$_____	$_____	Vet. Pension	$_____	$_____
Public Assistance	$_____	$_____	Dividends	$_____	$_____
Other	$_____	$_____			

SOCIAL SECURITY BENEFITS

	Patients		Spouse	
Social Security	$_____	$_____	$_____	$_____
Supplemental	$_____	$_____	$_____	$_____
SSI Income	$_____	$_____	$_____	$_____

UMEMPLOYMENT/DISABILITY INCOME

	Patients		Spouse	
Unemployment	$_____	$_____	$_____	$_____
Disability	$_____	$_____	$_____	$_____
Workman's Comp	$_____	$_____	$_____	$_____

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Some drug companies have Medication Assistance Programs that give certain medications to patients who do not have money to buy their prescriptions. Every company's program is different. Each company needs certain information about the patient, the patient's financial status, the medical problem, etc. Applications for these programs must be completed accurately, and required the patient and their argent to provide this information and sign the application.

Since the majority of applications require patient signature, we are offering to sign as your agent and provide any of the above information to the drug company.

(Please Initial One) I Do _____ I Do Not_____
give permission to the Good Samaritan Clinic's Medication Assistance Program worker to sign applications for medicine on my behalf to use the information provided in applying for medicine on my behalf.

_____
Patient or Guardian Name (Please Print)

_____ _____
Patient or Guardian Signature Date

All of the above information is true and correct. I understand that Good Samaritan Clinic will verify my information. I understand that if this information is inaccurate, then GSC will no longer try to provide medications to the above listed patient. I agree to notify Good Samaritan Clinic within ten days if I get medical health insurance, Medicare, or Medicaid. I also agree to notify Good Samaritan Clinic if my financial situation changes.

_____ _____
Patient or Guardian Signature Date