721 Snelling Ave S
St. Paul, MN 55116
Phone: 651-690-1311
Fax: 651-690-5274

PARKWAY CLINIC

CONTACT INFORMATION

PATIENT:

Name: _____ Date of Birth: _____

Address: _____City: _____ State: ____ Zip: _____

Preferred phone number: _____ ☐ Mobile ☐ Home ☐ Work

Alternate phone (optional): _____ ☐ Mobile ☐ Home ☐ Work

Email (optional): _____ ☐ Decline email communication

In the future, our computerized/electronic records will provide access to a "patient portal." Features will include viewing results and notes, requesting refills, asking questions, and more. Parkway Clinic will send you a formal letter and subsequent email when these options take effect.

Regardless of whether you elect to use the patient portal, Parkway will continue to offer services via phone and paper mailings. Just let us know your preferred method of communication.

Would you like to use the patient portal when it becomes available? ☐ Yes ☐ No

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____

City: _____ State: ____ Zip: _____

Preferred phone number: _____ ☐ Mobile ☐ Home ☐ Work

Alternate phone (optional): _____ ☐ Mobile ☐ Home ☐ Work

Signature of Patient/Authorized Representative _____

Relationship to Patient: ☐ Self
☐ Other: _____ **Date: _____**

(Please complete both sides)

OFFICE USE ONLY

Entered By: _____ Chart # _____ ☐ Scanned—please keep all forms together

REQUIRED FORM

Contact Info Confirmed By: _____

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RELEASE OF VERBAL INFORMATION

This form is optional
Providing the information below can help to facilitate communication for your care.

☐ I give permission to Parkway Clinic **to leave a voicemail message at my phone number** on file.

☐ I give permission to Parkway Clinic **to verbally discuss information about me with:**

Name: _____ Relationship: _____

Primary phone number: _____ ☐ Mobile ☐ Home ☐ Work

Secondary phone: _____ ☐ Mobile ☐ Home ☐ Work

Information can be shared regarding:
(Check all that apply)

☐ **Appointments/Scheduling Information**
☐ **Medical Information, including my symptoms, diagnosis, medications, and treatment plans**
☐ **Billing and payment information**
☐ **Other (describe): _____**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand I have the right to refuse to sign this authorization and that my care is not dependent on my signature.
This authorization shall be in effect until revoked in writing by the patient.

Signature of Patient/Authorized Representative: _____
Relationship to Patient: ☐ Self
☐ Other: _____ **Date: _____**

(Please complete both sides)

OFFICE USE ONLY

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OPTIONAL FORM

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PARKWAY CLINIC

INSURANCE & BILLING INFORMATION

Patient Legal Name:

_____ _____ ____
Last Name First Name MI

Date of Birth: _____

What is your race/ethnicity?
(Please select all that apply)

__ American Indian, Alaska Native or Indigenous
__ Asian
__ Black or African American
__ Hispanic or Latino/Latina/Latine
__ Native Hawaiian or Pacific Islander
__ White
__ Prefer to self-describe_____
__ Prefer not to specify

What is your preferred Language? _____

Patient Insurance Information

Insurance Carrier: _____ Group Number: _____

ID Number: _____

Health Insurance Policy Holder:
(If policy holder is the patient, skip this and sign below)

Name: _____ Relation to Patient: _____

Date of Birth: _____

Address: _____

City: _____ State: ____ Zip: _____ Phone number: _____

Signature of Patient/Authorized Representative _____

Relationship to Patient: ☐ Self
☐ Other: _____ **Date: _____**

OFFICE USE ONLY **(please complete reverse side)**

Entered By: _____ Chart # _____

REQUIRED FORM

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), **I have certain rights to privacy** regarding my protected health information. I understand that this **information can and will be used to:**

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly,
- Obtain payment from third-party payers,
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received a *Notice of Privacy Practices* from Parkway Clinic containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient/Authorized Representative _____

Relationship to Patient: ☐ Self

☐ Other: _____ **Date: _____**

(Please complete both sides)

OFFICE USE ONLY

Entered By: _____ Chart # _____

REQUIRED FORM