COMMUNITY HEALTHCLINIC

For office Use Only

☐ Photo ID
☐ Proof of Residency
☐ Food Stamps Letter
☐ Income
☐ Tax Returns

Admission Application

Date _____-_____-_____ Social Security#_____-_____-_____

Date of Birth_____-_____-_____ Referred by_____

Name_____

Address_____

City_____ State_____ Zip Code_____

Home phone_____ Cell_____

☐ Male ☐ Female Language_____

☐ Married ☐ Single

Race:

☐ Hispanic ☐ Caucasian ☐ Asian ☐ African American ☐ Middle Eastern

☐ American Indian ☐ Other_____

In case of emergency contact: Name_____ Phone_____

Do you receive federal or state assistance? Yes☐ No☐ Which?_____

Do you have medical insurance, Medicaid or Medicare? Yes☐ No☐ Which?_____

Are you working? Yes_____ No_____

Where:_____ Monthly Pay $_____

Is your spouse working? Yes_____ No_____

Where:_____ Monthly Pay $_____

Total Number of people living in household _____ (including children).

Parent/Guardian

Name_____ Relation _____

Address_____

City_____ State_____ Zip Code_____ Phone_____

Notice

We do not accept patients eligible for Medicaid or Medicare. We do not accept patients who are on the Collin County Indigent Care Program or any other healthcare program, healthcare insurance or companies that provide their own doctors.

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

*Signature*_____*Date*_____

COMMUNITY HEALTHCLINIC

Consent to Treatment by Volunteers

I understand that services I receive from Community Health Clinic may be provided by a volunteer who is providing care that is not administered for or in expectation of compensation.

I further understand that Texas law imposes limits on the recovery of damages from such a volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

1. The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization.
2. The volunteer commits the act or omission in the course of providing health care services to the patient.
3. The services provided are within the scope of the license of the volunteer, and before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges;
   (a) That the volunteer is providing care that is not administered for or in expectation of compensation; and
   (b) The limitations of the recovery of the damages from the volunteer in exchange for receiving the health care services.

I acknowledge that the health care providers, as volunteers, are providing me with care that is not administered for or in expectation of compensation, and in exchange for receiving the health care services, recovery of damages is limited.

( ) Myself
( ) The following person for whom I am legally responsible _____

Patient Signature_____Date_____

COMMUNITY HEALTHCLINIC

AUTHORIZATION TO USE AND DISCLOSE CONFIDENTIAL HEALTH INFORMATION

Community Health Clinic is an independent 501C3 charity clinic that provides health care services to individuals residing in McKinney and designated area to better coordinate health care provided to uninsured individuals, to overcome barriers to health care faced by uninsured individuals, and to implement appropriate disease management systems to improve the health status of uninsured individual patients. Community Health Clinic may need to use and share among themselves confidential health information. This use and disclosure will require an authorization by each uninsured individual (or individual's representative) who desires to participate. If you agree to authorize the use and disclosure of your confidential health information as set forth in this Form, please sign below.

I, _____, authorize CHC and healthcare providers affiliated with CHC to use, release, and disclose my confidential healthcare information for the purposes set forth above, to their employees, and healthcare providers affiliated with CHC.

I understand that "confidential health information" includes diagnoses, diagnostic tests and lab results, and drugs that have been prescribed for me and includes contact information (name, address, social security number, phone number, etc.) and demographic information (gender, race, age, etc.) that is housed in any of the medical records of CHC.

I understand that information released may include mental health, substance abuse, (e.g. drugs, alcohol) and/or HIV/AIDS status, diagnostic and treatment records. IF I DO NOT WANT THIS INFORMATION DISCLOSED, MY OPTION IS TO NOT SIGN THIS AUTHORIZATION. If I sign this Authorization, such information will be received, used, and disclosed by CHC as authorized by federal law.

I understand that this is a limited Authorization. I am only authorizing the release of confidential health information that included diagnoses, diagnostic tests and lab results, drugs that have been prescribed for me; contact information (name, social security number, address, phone number, etc.) and demographic information (gender, race, age, etc.) that is housed in any of the medical records of CHC or the following health care provider.

Patient Name_____

Address_____

Telephone_____

Patient Signature_____Date_____

COMMUNITY HEALTHCLINIC

Supplemental "No Income" Form

I, _____, do hereby attest that I and no individual living in my household have any income. If I or any individual living in my household receives Food Stamps and or help from the Housing Authority (HUD), I have attached all amounts received for Food Stamps or from the Housing Authority (HUD) to the application.

By signing below, I certify all information provided is true and accurate. I realize that if I have given any false information regarding any of the information in this statement, I will immediately and permanently be removed from Community Health Clinic.

Signature_____Date_____

Printed name_____

****

Please have all individuals providing support complete section below. You may attach multiple forms for each individual providing money to the household. If you receive Food Stamps or help from the Housing Authority (HUD), please include the Food Stamp print out with the application as well as this form.

I, _____, give _____
(person supporting patient) (patient's name)

money to pay for (please check all that apply) electricity gas house payment rent food utilities

other_____.

The total amount given is $_____ per month as a gift.

Signature _____Date_____

Printed Name_____

NOTARY: _____Date:_____

COMMUNITY HEALTHCLINIC

Self-Declaration of Income

I, _____, declare that I have been working and receiving payment doing

_____ in the amount of $_____ per (circle one) day, week or month. I do not have check stubs or any other documentation, and it is NOT possible to have the people who have paid me write a letter to prove any earnings. The reason I am unable to give any documentation is (example: work in flea market, have a road-side stand, employer refused to write letter, etc.)

other:_____

Signature_____Date_____

I, _____, personally know the above signed person, and I can attest that the above signed statement regarding their income is true to the best of my knowledge.

Witness Signature_____Date_____

Notary_____Date_____

COMMUNITY HEALTHCLINIC

Employer Statement of Income

_____ currently works for me doing _____
(name of employee) (work employee does for payment)

He/she is paid the GROSS amount before any deductions of $_____ on a (circle one) weekly,

bi-weekly, monthly basis. This employee has been employed by me or the company for at least 4 weeks and does not have health insurance through me or the company.

_____ _____
Signature of Employer Date

_____
Printed name of Employer

_____
Employer Company & Phone Number

COMMUNITY HEALTHCLINIC

Patient Agreement

Community Health Clinic is a non-governmental, non-profit agency which is designated to provide health care to those families in McKinney and designated area who have no other means of obtaining health care. Our clinic is staffed by volunteer doctors and nurses who are not paid for their services.

To better serve you, we ask you for your cooperation in following the policies listed below. If you are unable to follow these guidelines, or find them unacceptable, another health care provider may be better able to meet your needs.

I understand and agree to do the following:

1. I will inform CHC if my address, telephone number(s), income or insurance changes within 30 days of any change.
2. I will give CHC 24 hours' notice if I will be unable to keep my appointment.
3. New patients must arrive 30 minutes prior to their appointment time. Arriving late for an appointment, will result in being rescheduled for the next available time.
4. If I miss 3 appointments without notifying CHC, I understand that I may no longer be able to receive services at CHC.
5. I do authorize any health care professional associated with CHC to disclose any personal health information to other health care professionals, when medically necessary.
6. I do authorize the administrative staff of CHC to disclose my registration and screening information for the purpose of obtaining free health care at another facility.
7. I understand that I am solely responsible for the following through on testing and treatment ordered by the providers at CHC. I understand that if I fail to follow the provider's orders my treatment may be unsuccessful.
8. I understand that if I am uncooperative, verbally abusive, intoxicated or behave in an inappropriate manner, I may not be eligible for services at CHC and may be dismissed from CHC immediately.
9. I will keep my children with me at all times.

I have received a full explanation of CHC services and I understand and agree to all of the above. I understand I can be dismissed from the clinic as a patient, if I have given wrong information, misleading information, or if I fail to follow the policies above.

Patient signature_____Date_____

Privacy:

You have a right to have your interviews, examinations and treatment in surroundings that provide reasonable privacy. Your medical records are also private. Only legally authorized persons may see your records unless you request in writing for us to show them to someone else. A complete discussion of your privacy rights is attached as "HIPAA Notice of Privacy Practices." By signing this document you are indicating that you have received this Notice. The Notice details the various rights granted to you by the Health Insurance Portability and Accountability Act (HIPAA).

Patient signature_____Date_____