SHEPHERDS CARE MEDICAL CLINIC

New Patient Eligibility Form

Name: ____
Last *First* *M.I.*

Social Security Number or Government ID: ______________________

Birth Date: ______________ Marital Status: ______________________

Employer: ______________________ Work Phone: ______________________

What county do you live in?______________ Do you have transportation? ______________

Where do you live and for how long? ______________

Insurance Information

	Yes	No
Does your employer offer health insurance?	☐	☐
Do You have Medicare?	☐	☐
Do you have Medicaid?	☐	☐
Do you have private Insurance?	☐	☐
Are you a Veteran of the Military?	☐	☐
Are you a patient of any of the following:	☐	☐
Alliance Medical Ministry, Urban Ministries	☐	☐

Proof Of Income Sources:

- ☐ Pay Stubs
- ☐ Child support
- ☐ Food Stamps
- ☐ 1040 Income Tax Forms
- ☐ Alimony (any Income)
- ☐ Unemployment Check Stub
- ☐ Social Security (Include Children)
- ☐ Other source of income:

Household Members and Income: (List all in home)

Who	Name	DOB	Source of Income	Monthly	Yearly
Patient					
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					
		Total Income			

200% of the Federal Poverty Level 2018

Family Size	Monthly Income	Gross Annual Income
1	$2,023	$24,280
2	$2,743	$32,920
3	$3,463	$41,560
4	$4,183	$50,200

For each additional person add

______________ Patient qualifies for SCMC Services.

______________ Patient does not qualify for SCMC services

I agree that the financial information given is correct.

Patient Signature ______________________________

Witness ______________________________

Date ______________________________

Revised 02/15/2018

Shepherds C[illegible] [illegible]al Clinic

304 B Pony Road, Zebulon NC 27597

Date: ______________ DOB ______________

Name: / *Nombre* ____

Last / Apellido *First / Primer* *M.I./ Inicial*

Address: / *Dirección* ____

Street Address / Calle *Apartment/Unit #*

____

City / Ciudad *County:* *State* *ZIP Code/Codigo*

Home Phone / *Teléfono* ______________________ Social Security Number: / *Numero de Segura Social* ______________________

Do you have medical insurance, Medicare or Medicaid? / *¿Tiene usted seguro medico, Medicare o Medicaid?* ☐ Yes/ *Si* ☐ No / *No*

Reason for visit / *Razón de su visita*

☐ Diabetes / Hypertension *Diabetes /Hipertensión* ☐ Primary Care/ *Medicina Primaria*
☐ Gynecology /PAP *Ginecología / PAP* ☐ Other / *Otro*

Do you have an immediate medical need? / *¿Necesita atención médica inmediata?* ☐ Yes/ *Si* ☐ No / *No*

Why? / *¿Porque?* ____

Are you... / *Esta usted...*

☐ Employed / *Empleado* ☐ Unemployed / *Sin empleo* ☐ Retired / *Jubilado*
☐ Disabled / *Disabilitado* ☐ Student / *Estudiante* ☐ Other / *Otro*

Name and address of employer / *Nombre y dirección de empleador* ____

Race / *Raza*

☐ American Indian/Alaskan ☐ Asian/Pacific Islander ☐ Black/African American
☐ Hispanic/Latino ☐ White/Caucasian ☐ Other / Otro

Country of origin / *País de origen* ______________________ **County you live in:** ______________________

Language Preference / *Idioma Preferido* ____

Do you need an interpreter? / *¿Usted necesita intérprete?* ☐ Yes / *Si* ☐ No / *No*

Gender / *Género*

☐ Female / *Femenino* ☐ Male / *Masculino*

Marital Status / *Estado Marital*

☐ Single / *Soltero* ☐ Married / *Casado*
☐ Divorced / *Divorciado* ☐ Widowed / *Viudo*

Do you live... / *Usted vive...*

☐ Alone / *Solo* ☐ With spouse / *con esposo* ☐ With children / *Con hijos*
☐ With family / *Con familia* ☐ Other / *Otro* **Own** _____ **Rent** ____ **County** ________

Spouse Name / *Nombre de esposo(a)* ____

Emergency Contact / *Contacto de emergencia* ____

Name / Nombre

____

Telephone / Telefono

Shepherds Care Medical Clinic is a free health clinic for low-income, uninsured adults. We will ask for documentation of your income.

Clínica Shepherds cari medica clínica gratis para adultos de bajos ingresos, sin seguro medico. Nosotros pediremos de Salud Comunitaria documentación de sus ingresos.

Shepherd's Care Medical Clinic

CONSENT TO TREATMENT, RELEASE AND ACKNOWLEDGEMENT FORM

Patient Name: ____

CONSENT TO TREATMENT

I request those physicians and other healthcare professionals who care for me to perform routine examinations, diagnostic procedures, hospital care and therapeutic treatments, which in their judgment, become necessary while I am a patient of the Shepherd's Care Medical Clinic. Routine diagnostic procedures and medical treatments include but are not limited to ECGs, x-rays, physical therapy, blood tests and administration of medications. I also consent to medical recording or filming necessary in the judgment of my physician, to document the course of my injury or illness and to provide appropriate medical care, performance improvement and education. I acknowledge that I have the right to request stopping of any recording or filming during the filming and up until a reasonable time before the recording or film is used.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the Shepherd's Care Medical Clinic to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I understand that Shepherd's Care Medical Clinic, in order to deliver quality healthcare, develops and maintains health information which may include physician notes, history and physical, medication reports, tests and test results, and treatment plans. I concur that this health information is used for the following:

- care and treatment plans
- communication between interdisciplinary healthcare providers
- quality control by Shepherd's Care Medical Clinic

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Physician Practice's Notice of Privacy Practices ("Notice"). I understand that information Shepherd's Care Medical Clinic acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the Notice or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

______________________________ ______________________________

Signature Witness

______Patient _______Substitute Decision Maker ________________________**DATE COMPLETED**

______________________________ ______________________________

If Substitute Decision Maker, state relationship If Substitute Decision Maker, state reason

Shepherd's Care Medical Clinic
Patient Agreement

Program Overview
Area physicians and Shepherd's Care Medical Clinic are volunteering their services to help you get well and stay well. This is not a government program or an 'entitlement'. Shepherd's Care Medical Clinic seeks to link Wake, Johnston, Nash and Franklin County residents with a medical home so that health services can be received on a regular basis. Shepherd's Care Medical Clinic does not cover non-emergent care in the emergency room or ambulance services. By signing this form, you authorize Shepherd's Care Medical Clinic to verify your financial and residency information realizing that this program may be stopped should funding not be available.

Program Benefits
When enrolled in Shepherd's Care Medical Clinic you will be provided a medical home. Other benefits include:

- Access to a medical home that knows you and will provide well and sick care.
- Access to a medication assistance program (for long-term, chronic medicines).
- Access to lab and diagnostic services arranged by your regular doctor/medical home.
- Limited access to appropriate specialist referrals arranged by your regular doctor/medical home.

Patient Responsibilities
You understand/agree that:
_____1.Specialty referrals will be arranged by your regular doctor/medical home as needed for your care. Limited specialty care appointments are available and given on a first come first serve basis and may have waiting list.
_____2.You will keep every medical appointment or give at least 24 hours' notice to cancel. You will be on time for your appointment and show your appreciation by saying thank you to the provider.
_____3.You will follow your treatment plan. For example, get prescribed medicines and take as directed.
_____4.You will promptly supply any information that may be requested by the program.
_____5.You will remain aware of the expiration date of your eligibility in this program
_____6.You will immediately contact Shepherd's Care Medical Clinic if your income changes or if you become covered by **Medicare, Medicaid, private insurance or other health insurance or medical benefits**.
_____7.You will contact Shepherd's Care Medical Clinic immediately with any change in address and/or telephone number.
_____8. During the duration of your enrollment you will allow all financial and health information to be shared with other individuals, organizations and agencies solely at the discretion of Shepherd's Care Medical Clinic.
_____9.You must provide all documents or information needed by other agencies such as Health Services or Department of Social Services in order to obtain Charity Care
By signing below, I confirm that I understand and agree to the above conditions. I also understand that if I do not follow the Patient Responsibilities listed, then I will be discharged from the clinic. Questions, please call 919-404-2474

Patient Signature: ______________________________
Address____

Print Name: ______________________________ Date___________ Email address:___________________________

By signing below, I confirm that I nor my spouse (if living in the home) have no income coming into the home at this time. This includes earned income, social security payments, unemployment benefits, etc.

Patient Signature:______________________________
Date:____________________________

Shepherd's Care Medical Clinic

Serving the uninsured one person at a time

Dear Patient,

We are very glad that you have chosen to come to Shepherd's Care Medical Clinic for your medical care. We are a free clinic in that we do not charge for being seen by any of the health care providers.

One of the services we provide is labs, drawing blood and sending your blood to Laboratories for evaluation. Shepherd's Care has a partnership with Rex and Quest labs for a very low cost to do your lab work. We ask that you consider donating the cost of the labs. By doing this it helps us stretch the already tight budget we have, so we can keep the doors open to serve you and others like you who have medical needs and no insurance.

If you have any questions, please feel free to ask at any time.

Thank you for your help.

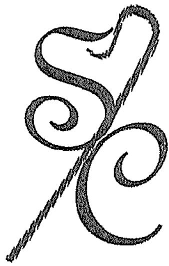
Sincerely,

Leona Doner
Executive Director
Shepherds Care Medical Clinic

I acknowledge that I have read and understand the above letter.

Patient: ______________________________ Date: ____________

304 B Pony Rd., Zebulon, NC 27597
Office: 919-404-2474 Fax: 866-929-4189



Shepherd's Care Medical Clinic

Serving the uninsured one person at a time

Dear Patient:

Due to the very high volume of No Call No Show appointments, it has been decided that the clinic will only allow One (1) No Call No Show. If you have another No Call No Show, you will then be terminated for One (1) calendar year beginning from the time of the second No Call No Show. Please be mindful, if you are terminated your prescriptions will be unable to be filled by the Doctor.
If you cannot make it to your appointment, please contact the clinic and Cancel or Reschedule. This will open up an appointment slot for someone else to be seen.

These measures have been taken due to a large amount of unnecessary occupied appointment slots that can potentially be filled with patients in need.

To avoid being terminated from our clinic please allow us at least 24 hours for cancellations.

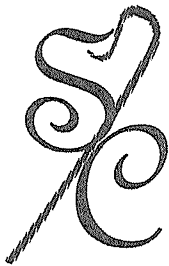
Thank you for your patience.

Sincerely,

Leona Doner
Executive Director

Patient Signature: ________________________________ Date: ______________

304 B Pony Rd., Zebulon, NC 27597
Office: 919-404-2474 Fax: 919-404-2475



Shepherd's Care Medical Clinic

Serving the uninsured one person at a time

PROTECTED HEALTH INFORMATION DESIGNATION FORM

Patient's Name ______________________________ MR # __________

You may grant Shepherd's Care Medical Clinic a written authorization to release your protected health information (PHI) to anyone you designate and for any purpose.

Please complete the following questions. Only provided information that you consider acceptable as a means of contacting you and your designated contacts. In the case of a serious medical emergency or in cases permitted or required by law, this written authorization will not be necessary. See the Notice of Privacy Practices for more information.

You may revoke any authorization in writing at any time. Upon receipt of the revocation in writing, we will stop using or disclosing your PHI.

My Home Number: ______________________ OK to leave a message? Yes/No
My Work Number: ______________________ OK to leave a message? Yes/No
My Cell Number: ______________________ OK to leave a message? Yes/No
My Email Address: ______________________ OK to leave a message? Yes/No
My Mailing Address for test results, appointments, billing problems:

____

(Address)

______________________________ NC ______________

(City) **(Zip Code)**

Upon my request, I authorize Shepherd's Care Medical Clinic to disclose my protected health information (PHI) to:

Name: ______________________ Phone number: ______________
Address: ______________________________________
City: __________________ State: ________ Zip Code: __________
Relationship with the patient: ______________________________
Specific information you would like them to know OR not know:

____

____

____

______________________________ ______________

Patient's /Legal Guardian /Power of Attorney Signature **(Date)**

304 B Pony Rd., Zebulon, NC 27597
Office: 919-404-2474 Fax: 919-404-2475

CHECK IF YOU HAVE HAD / *MARQUE SI HA TENIDO:*

- ☐ **HIGH BLOOD PRESSURE** *PRESIÓN ALTA*
- ☐ **HEART ATTACK** *INFARTO*
- ☐ **HEART MURMUR** *MURMULLO DELCORAZÓN*
- ☐ **HEART FAILURE** *PARO CARDÍACO*
- ☐ **DIABETES** *DIABETIS*
- ☐ **HIGH CHOLESTEROL** *COLESTEROL ALTO*
- ☐ **PNEUMONIA** *PULMONÍA*
- ☐ **ASTHMA** *ASMA*
- ☐ **EMPHYSEMA** *ENFISEMA*
- ☐ **GALLSTONES** *BILIAR*
- ☐ **STOMACH ULCER** *ÚLCERA DEL ESTOMAGO*
- ☐ **HIATAL HERNIA** *HERNIA HIATAL*
- ☐ **COLON POLYPS** *PÓLIPOS DEL RECTO*
- ☐ **DIVERTICULITIS** *DIVERTICULÍTIS*
- ☐ **HEPITITIS** *HEPETITIS*
- ☐ **PHLEBITIS** *FLEBITIS*
- ☐ **THYROID** *TIROIDES*
- ☐ **ANEMIA** *ANEMIA*
- ☐ **CANCER** *CANCER*
- ☐ **STROKE** *DERRAME CEREBRAL*
- ☐ **CONVULSION** *CONVULSIONES*
- ☐ **DEPRESSION** *DEPRESIÓN*
- ☐ **ARTHRITIS** *ARTRITIS*
- ☐ **ALCOHOLISM** *ALCOHOLISMO*
- ☐ **KIDNEY STONE** *PIEDRAS DEL Riñón*
- ☐ **PELVIC INFECTION** *INFECCIÓN DEL PELVIS*
- ☐ **VENEREAL DISEASE** *ENFERMEDAD VENARIA*
- ☐ **TUBERCULOSIS** *TUBERCULÓSIS*
- ☐ **HEMATIC FEVER** *FIEBRE REUMÁTICA*
- ☐ **SHINGLES** *HERPES*

FAMILY MEDICAL HISTORY/ *HISTORIAL MEDICO FAMILIAR*

	MOTHER *MADRE*	**FATHER** *PADRE*	**SIBLING** *HERMANOS*
HEART ATTACK/*INFARTO*			
HIGH CHOLESTEROL/ *COLESTEROL ALTO*			
DIABETES/ *DIABETIS*			
STROKE */DERRAME CEREBRAL*			
CANCER (TYPE)/ *TIPO*			
TUBERCULOSIS/ *TUBERCULÓSIS*			
BLEEDING DISORDER / *HEMORRAGIA*			
ALCOHOLISM / *ALCOHOLISMO*			

MOTHER LIVING? *¿MADRE VIVE?* ☐ YES *SÍ* ☐ NO *NO* **CAUSE OF DEATH?** *CAUSA DE MUERTE* ______

FATHER LIVING? *¿PADERE VIVE?* ☐ YES *SI* ☐ NO *NO* **CAUSE OF DEATH?** *¿CAUSA DE MUERTE?* ______

HABITS/ *HABITOS*

HAVE YOU SMOKED? *¿Ha FUMADO?* ☐ **YES** *SI* ☐ **NO** *NO* **HOW MANY PACKS A DAY?** *CUANTAS CAJETILLAS AL DIA?* ___ **HOW MANY YEARS?** *POR CUANTOS AÑOS* ___ **QUIT?** *DEJÓ* ___ **YEARS?** *AÑOS* ___

ANY OTHER TOBACCO USE? *¿USA OTRO TABACO?* ______ **CUPS OF COFFEE/CAFFEINATED BEVERAGES/DAY?** *TAZAS DE CAFÉ/BEVIDAS CAFEINADAS AL DÍA* ______

DO YOU DRINK ALCOHOL? *¿TOMA ALCOHOL?* ☐ **YES** *SI* ☐ **NO** *NO* **HOW OFTEN?** *FRECUENCIA* ______ **HOW MUCH?** *CUANTO* ______

DO YOU EXERCISE? *¿HACE EJERCICIOS?* ☐ **YES** *SI* ☐ **NO** *NO* **HOW OFTEN?** *FRECUENCIA* ______ **WHAT TYPE?** *QUE TIPO* ______

DO YOU SLEEP WELL? *¿DUERME BIÉN?* ☐ **YES** *SI* ☐ **NO** *NO* **HOW MANY HOURS?** *¿CUANTAS HORAS?* ______

DO YOU FOLLOW ANY SPECIAL DIET? *¿SIGUE ALGUNA DIETA ESPECIAL?* ☐ **YES** *SI* ☐ **NO** *NO* **WHAT TYPE?** *QUE TIPO* ______

DO YOU WEAR SEATBELTS? *¿USA CINTURÓN DE SEGURIDAD?* ☐ **YES** *SI* ☐ **NO** *NO* **HOW OFTEN?** *FRECUENCIA?* ______

DO YOU SELF-EXAM? *¿SE HACE EXAMEN PROPIO?* **(BREAST OR TESTICULAR)** *(CENOS O TESTICULAR)* ☐ **YES** *SI* ☐ **NO** *NO*

DO YOU REGULARLY USE? *¿USA REGULARMENTE?* ☐ **ASPIRIN** *ASPIRINA* ☐ **PAIN RELIEVERS** *ALIVIANTES* ☐ **LAXATIVES** *LAXANTES* ☐ **COLD PREPS** *DE CATARRO* ☐ **CALCIUM** *CALCIO* ☐ **VITAMINS** *VITAMINAS*

ARE YOU AT RISK FOR HIV INFECTION? *¿TIENE RIESGO DE LA INFECCIÓN VI?* ☐ **YES** *SI* ☐ **NO** *NO*

DO YOU HAVE A HISTORY OF SUBSTANCE USE? *? TIENE HISTORIA DE USO DE DROGAS?* ☐ **YES** *SI* ☐ **NO** *NO* **WHAT TYPE?** *¿QUE TIPO?* ______

SHEPHERDS CARE MEDICAL CLINIC

PERSONAL HISTORY REVIEW
HISTORIAL PERSONAL

NAME: ____________________
NOMBRE

DATE OF BIRTH: ____________ **AGE:** ____________
FECHA DE NACIMIENTO *EDAD*

REASON FOR VISIT: ____________________
RASÓN DE LA VISITA

PRESENT MEDICATIONS: ____________ ____________ ____________
PRESENTE MEDICACIONES

PHYSICIANS SEEN IN THE LAST 5 YEARS
MEDICOS VISTO EN LOS ULTIMOS 5 ANOS:

NAME OF DOCTOR OR PROVIDER ____________
NOMBRE DEL DOCTOR O PROVEEDOR

LOCATION (CITY, STATE) ____________
LOCALIDA (CIUDAD/ESTADO)

PRIMARY PROBLEM CARED FOR ____________
PROBLEMA PRINCIPALE

NAME OF DOCTOR OR PROVIDER ____________
NOMBRE DEL DOCTOR O PROVEEDOR

LOCATION (CITY, STATE) ____________
LOCALIDA (CIUDAD/ESTADO)

PRIMARY PROBLEM CARED FOR ____________
PROBLEMA PRINCIPALE

SOCIAL HISTORY/ *HISTORIAL SOCIAL*

☐ **SINGLE** *SOLTERO* ☐ **MARRIED** *CAZADO* ☐ **DIVORCED** *DIVORCIADO* ☐ **WIDOWED** *VIUDO* ☐ **SEPARATED** *SEPARADO*

OCCUPATION/PRIOR JOBS: ____________________
OCUPACIÓN PREVIOS TRABAJOS

WHO LIVES AT HOME WITH YOU? ____________________
¿QUIEN VIVE EN CASA CON USTED?

DO YOU HAVE A LIVING WILL? ☐ YES *SI* ☐ NO *No*
? TIENE TESTAMENTO DE VIDA?

HEALTH CARE POWER OF ATTORNEY? ☐ **YES** *SI* ☐ **NO** *No*
?POTESTAD DE ABOGADO PARA EL CUIDADO DE LA SALUD?

PAST MEDICAL HISTORY/*PASADO HISTORIAL MEDICO*

ALLERGIES (MEDICATION & REACTION: ____________________
ALERGIAS MEDICINAS & REACCIONES

LIST SERIOUS ILLNESSES AND INJURIES OR OPERATIONS AND APPROXIMATE YEAR. EXCLUDE NORMAL PREGNANCIES.
LISTA DE ENFERMEDADES SERIAS Y FRACTURAS U OPERACIONES Y Año APROXIMADO. EXCLUYA EMBARAZOS NORMALES

YEAR *AÑO*	SERIOUS ILLNES, INJURY OR OPERATION *ENFERMEDAD SERIA, FRACTURA U OPERACIÓN*	NAME OF HOSPITAL *NOMBRE DEL HOSPITAL*	CITY AND STATE *CIUDAD Y ESTADO*

HAVE YOU EVER BEEN TREATED BY A PHYCHIATRIST/PHYCOLOGIST? ☐ **YES** *SI* ☐ **NO** *No*
¿ALGUNA VEZ A SIDO TRATADO POR PSIQUIATRA O PSICÓLOGO?

REASON? ____________________
? *RASÓN?*

OBSTETRICAL: *OBSTETRÍCO* **PREGNANCIES:** ______ *EMBARAZOS* **ABORTIONS:** ______ *ABORTOS* **MISCARRIAGES:** ______ *ESPONTANEOS*

LIVING CHILDREN ______ *NiÑos VIVIENTES* **SONS** ______ *HIJOS* **DAUGHTERS** ______ *HIJAS*

IMMUNIZATIONS: *VACUNAS* ☐ **TETANUS** *TETANO* ___ **YRS AGO** *AÑos A TRAS* ☐ **RUBELLA** *RUBEOLA* ☐ **HEPATITIS B** *HEPATITIS B* ☐ **PNEUMONIA** *PULMONÍA*

EVER HAD TRANSFUSION? ☐ **YES** *SI* ☐ **NO** *NO*
? *ALGUNA VEZ A TENIDO UNA TRANSFUSION?*

CHART NO: ____________

DATE: ____________

C:\Users\clerical\Documents\Eligability application\Medical_History[1].doc
Rev:07/20/2016