COMMUNITY MEDICAL CLINIC

URGENT CARE & WALK-IN PATIENT PACKET

Pennyroyal Healthcare Services, Inc DBA Community Medical Clinic
1102 S Virginia Street - Hopkinsville, KY 42240 - 270-632-6741 - 270-632-6742 (Fax)
Dental 1102 S Virginia Street Suite B - Hopkinsville, KY 42240 - 270-632-3088 - 270-632-6742 (Fax)
244 Thompsonville Lane - Oak Grove, KY 42262 - 270-632-6743 - 270-632-6744 (Fax)
1022 W Main Street - P.O. Box 151 - Princeton, KY 42445 - 270-365-0227 - 270-365-2559 (Fax)

In order to help the check in process, please fill in ALL information.

PART A

I. Patient Information

_____, _____, _____
Last Name ***First Name*** ***Middle Name***

What name would you like to go by? _____

Address:_____ **Zip Code**: _____
Home Phone: (___)_____ **Cellular:** (___)_____**Work**: (____)_____
Email Address:_____ **Preferred Communication:** ☐Phone ☐Text ☐Email
Preferred Phone Contact: ☐ Home ☐ Cell ☐ Work

Circle Gender at Birth: M / F **SSN:** _____ - _____ -_____ **Date of Birth:** _____
Gender Identification (please choose one): ☐Male ☐ Female ☐Transgender- male-to-female
☐ Transgender-female to male ☐ Non Binary
Sexual Orientation (please choose one): ☐ Lesbian or Gay ☐ Straight or Heterosexual ☐ Bisexual
☐ Something Else ☐ Don't Know ☐ Choose Not To Disclose

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow / Widowed ☐ Unknown

Education: (choose the highest education level completed)
☐ None ☐ 1-6 grade ☐ 7-8 grades ☐ some high school ☐ GED ☐ High school diploma ☐ Associates Degree
☐ Bachelors' degree ☐ Masters' degree or higher ☐ Some College

Race: ☐ Native American/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White
☐Middle Eastern/North African ☐ Other

Ethnicity: ☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino
Other:_____

Preferred Language: ☐English ☐Spanish ☐Other_____
☐ Interpreter Needed?

We offer interpreter services through AMN Healthcare language services

Living Situation: ☐ Homeless ☐ Not Homeless ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other ☐ Unknown

Agricultural Worker: ☐ Migrant ☐ Seasonal ☐ Not an Agricultural Worker

Are you a U.S. Veteran? ☐ Yes ☐ No

IN CASE OF EMERGENCY

Please contact (name):_____ **Phone(s):**_____

Address:_____ **Relation:**_____

Preferred Pharmacy:_____**Phone:**_____

INSURANCE INFORMATION (Complete this section only if your insurance card is not present)

Primary Insurance: _____ **ID#**_____ **Group#**_____

Subscriber's Name:_____ **DOB:**_____ **Phone#**_____

Secondary Insurance:_____ **ID#**_____ **Group#**_____

Subscriber's Name:_____ **DOB:**_____ **Phone#**_____

Subscriber Address (if different than the patient): _____

Subscriber Social Security#:_____

II. RESPONSIBLE PARTY INFORMATION

Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full-Time Student ☐ Retired ☐ Active Military ☐ Unknown

Responsible Party Name: _____**Employer Name:**_____

Employer Address: _____**Employer Phone:**_____

Required Information and Acknowledgments:

- Consent to Treatment: I authorize necessary exams and treatments, understanding that medicine involves risks and no outcomes are guaranteed.
- Release of Records: I allow Community Medical Clinic to release my medical records for referrals and continuity of care, excluding behavioral health, HIV/AIDS, and substance use records unless I complete a separate consent. Referrals will be made to my preferred qualified provider when available. This release remains valid until revoked in writing.
- Appointments: I will cancel at least 24 hours in advance. Three missed/canceled visits, or 3 no call/no shows within 12 months, may result in discharge.
- Transportation: I may request assistance if I have difficulty getting to an appointment.
- Privacy: I have received the Notice of Privacy Practices.
- Payment: I agree to pay all charges. Insurance will be filed as a courtesy, with 30 days allowed for processing.

Patient / Representative Signature:_____ **Date:**_____

Patient's Legal Representative's Signature (if needed)_____**Date:**_____

V. HOUSEHOLD INCOME INFORMATION

Note: ***As a Federally Qualified Health Center (FQHC), we provide Sliding Fee Scales which may help you with your health care expenses. To help us determine if you may qualify, please answer below.*** **This information is only used to obtain the grants we use to help those who do not have insurance and will not affect you in any adverse way.**

What is your annual household income?_____ How many people are in your household?_____

☐ No Income ☐ Less than 24,999 ☐ 25, 000 to 39,999 ☐ 40,000 to 59,999 ☐ 60,000 to 99,999

☐ 100,000 or more

If you are interested to know more about our Sliding Fee Scale Program, please fill out the enclosed Sliding Fee Scale discount program section below.

A sliding scale **discount program is available for our uninsured and under-insured patients who may have difficulty paying.**

Pennyroyal Healthcare Services, Inc.

2025 Sliding Fee Schedule Medical and Behavioral Health
(Based on 2025 DHHS Federal Poverty Guidelines)
Effective February 2025

Poverty Level	Class A	Class B	Class C	Class D	Class E
	FPI 100% or below	FPI 101%-125%	FPI 126%-150%	FPI 151%-200	FPI > 200%
	Discount				
Family Size	$20	75%	50%	25%	0%
1	$15,650	$19,563	$23,475	$31,300	$ 30,121
2	$21,150	$26,438	$31,725	$42,300	$ 40,881
3	$26,650	$33,313	$39,975	$53,300	$ 51,641
4	$32,150	$40,188	$48,225	$64,300	$ 62,401
5	$37,650	$47,063	$56,475	$75,300	$ 73,161
6	$43,150	$53,938	$64,725	$86,300	$ 83,921
7	$48,650	$60,813	$72,975	$97,300	$ 94,681
8	$54,150	$67,688	$81,225	$108,300	$ 105,441
For each additional person, add	$6,330				

□ Yes, I am interested in information regarding the sliding scale program.

□ No, I am not interested at this time in the sliding scale program and I do not wish to disclose my income.

Signature: _____

Date: _____

Once the paper is signed, please return it to the receptionist.

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HEALTH QUESTIONNAIRE

Name: _____ **Birth Date**: ____/_____/_____ **Date**: ____/_____/_____
Last First MI

Gender: ☐ Male ☐ Female, if yes : ☐ Pregnant? ☐ Breastfeeding?

Reason for visit today? _____

List all your current medications, including non-prescription drugs: ☐ None _____

_____

_____

Medication Allergies: ☐ No known allergies

_____

PAST MEDICAL HISTORY (Check all that apply & Specify) ☐ NONE APPLY

☐ Allergies _____
☐ Anxiety_____
☐ Asthma_____
☐ Arthritis_____
☐ Cancer _____
☐ Depression_____
☐ Diabetes (type)_____
☐ Emphysema/COPD_____
☐ Epilepsy/Seizure Disorder _____
☐ Headaches_____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ High Cholesterol_____
☐ Kidney Disease_____
☐ Liver Disease_____
☐ Stroke_____
☐ Thyroid Disease_____
☐ Other (specify)_____

HOSPITALIZATION & SURGERY (Check all that apply, specify and write in date below) ☐ NONE APPLY

☐ Appendix _____
☐ Adenoids _____
☐ Back _____
☐ Breast _____
☐ Heart Surgery _____
☐ Hernia _____
☐ Hysterectomy _____
☐ Tonsillectomy _____
☐ Tubal Ligation _____
☐ Vasectomy _____
☐ C-Section _____
☐ Other (specify)_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you smoke? ☐ No ☐ Yes _____ packs/day

Do you drink alcoholic beverages? ☐ No ☐ Yes

For the MINOR patient:

Child lives with: ☐ Parents ☐ Grandparents

☐ Other _____

Do you use any recreational drugs or medications not prescribed to you? ☐ No ☐ Yes, _____

I have read the above information and consent that it is correct to the best of my knowledge. I authorize Health First Urgent Care and its health care providers to render necessary treatment for my condition.

_____ _____
Signature of Patient/Guardian **Date**

This form has been reviewed by the treating physician:

_____ _____
Signature of Physician **Date**

Name: _____

Date of birth: _____

PRAPARE Assessment

1. What is your housing situation today? (Choose one of the following.)
    a. I have housing
    b. I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)

2. Are you worried about losing your housing? (Choose one of the following.)
    a. Yes
    b. No

3. What is your main health insurance? (Choose one of the following.)
    a. None/uninsured
    b. Medicaid
    c. CHIP Medicaid
    d. Medicare
    e. Other public insurance (not CHIP)
    f. Other public insurance (CHIP)
    g. Private Insurance

4. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (Choose all that apply.)
    a. Food
    b. Clothing
    c. Utilities
    d. Childcare
    e. Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)
    f. Phone
    g. Other (enter written answer):_____

5. In the past year, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Choose all that apply.)

    a. Yes, it has kept me from medical appointments or from getting my medications.
    b. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need.
    c. No

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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