Community

Medical Clinic

Community Medical Clinic: Community Health Center (*Adult Intake Form*)

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

Sexual Orientation (please choose one): ☐ Lesbian or Gay ☐ Straight (not Lesbian or Gay) ☐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 ☐ some college ☐ Bachelors' degree ☐ Masters' degree or higher

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

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

Other:_____

Preferred Language: ☐English ☐Spanish ☐Other_____

☐ Interpreter Needed?

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

Who is / was your last Primary Care Provider? _____

Reason for Transfer of Care (if transferring):_____

How did you hear about us?_____

IN CASE OF EMERGENCY

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

Address:_____**Relation:**_____

Preferred Pharmacy:_____**Phone:**_____

INSURANCE INFORMATION

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): _____

_____

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:**_____

Are you seeking treatment that is related to a Workers Compensation or Auto Accident injury? ☐ Yes ☐ No

Please List anyone here that you wish to have access to your health care information in the invent you are unavailable. (i.e. - Pick up a prescription, receive results, make and confirm appointments)
List exclusion to the above permission's

_____

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.

Community

Medical Clinic

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

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

□ No, I am not interested at this time in the sliding scale program.

Signature: _____

Date: _____

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

Pennyroyal Healthcare Services

Better Health Through Professional Care

Community Medical Clinic - 310 Hawthorne St. - P.O. Box 151 - Princeton, KY 42445
270-365-0227 - 270-365-2559 (Fax)

Sliding Fee Discount Application

It is the policy of Community Medical Clinic to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (Print) _____

Signature _____ Date _____

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		

Community Medical Clinic
Medical Record Release (From)

1102 South Virginia Street
Hopkinsville, KY. 42240
Phone: 270-625-6741
Fax: 270-632-6742

Requesting From: _____
_____
_____
Fax: _____

PLEASE MAIL IF OVER 25 PAGES

RE: _____

Date(s) of Requested information: _____

DOB: _____

___Health & Physical ___Medication History ___Lab Report

___Height/Weight/Vitals ___Length of Treatment ___Treatment Notes

___Physical Health Evaluation ___Discharge Summary ___Diagnosis

___Other_____

I understand the purpose for releasing this information if for:

_____

_____

I understand I may refuse to sign this authorization and my refusal will not prevent my receiving services.

I understand I may revoke this authorization, at any time, if requested in writing to Community Medical Clinic, except if Community Medical Clinic has already undertaken an action in reliance upon it, and that in any event this consent expires automatically as follows:

_____
(Specify date, event or condition)

I understand pursuant to K.R.S. 304 17A-555-My Protected Health Information, released under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to be re-disclosure.

I have read and understand this authorization.

_____ _____
(Individual Signing Authorization) (Date Signed)

If not signed by the client, specify basis for authority to sign: ___Parent ___Spouse ___Personal Representative ___Other:

_____ (Descript Authority to Sign)

_____ _____
(Staff Signature) (Date Signed)

Community Medical Clinic
HIPPA Release of Information (To)

I, _____ authorize the following from my Protected Health Information:

___Health & Physical ___Medication History ___Lab Report

___Height/Weight/Vitals ___Length of Treatment ___Treatment Notes

___Physical Health Evaluation ___Discharge Summary ___Diagnosis

___Other_____

This information may be released to:

Spouse: _____

Child(ren): _____

Other: _____

I understand I may revoke this authorization, at any time, if requested in writing to Community Medical Clinic, except if Community Medical Clinic has already undertaken an action in reliance upon it, and that in any event this consent expires automatically.

I understand pursuant to K.R.S. 304 17A-555-My Protected Health Information, released under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to be re-disclosure.

I have read and understand this authorization.

_____ _____

(Individual Signing Authorization) (Date Signed)

If not signed by the client, specify basis for authority to sign: ___Parent ___Spouse ___Personal Representative
___Other: _____(Descript Authority to Sign)

_____ _____

(Staff Signature) (Date Signed)

VI. Required Information and Acknowledgements

Release of Medical Records

In the event that my physician / provider recommends (and I agree to) referral to a specialist, an outside Health Care Center, or other outside medical provider, I hereby authorize Community Medical Clinic to release my medical records as required to the indicated specialty physician, provider and/or the referral health center for the purpose of continuity of care.

I understand that this release does not apply to my behavioral health records, HIV/AIDS status, nor substance (drug, alcohol, etc.) abuse information, if it exists. If there is need for the release of behavioral health records, substance abuse history, or HIV/AIDS status, I will be notified. I will need to complete another Release of Information form specifically granting my consent for such release, if I agree to the records transfer.

I also understand that if I am being referred to a specialist physician or provider, or to a specialty health center, Community Medical Clinic will make the referral to the qualified entity of the patient's choice. If the patient's preferred entity refuses the referral, can't see the patient in a timely manner, or is unavailable, the Community Medical Clinic referral team will seek 'likes specialists' (i.e. physicians, providers, or specialty health centers) to provide care for the patient.

I understand that this release of my medical information is required to facilitate a referral (which is made by my Community Medical Clinic provider and accepted by me) stays in force unless I revoke it in writing to Community Medical Clinic.

Patient Signature:_____ **Date**:_____

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

CONSENT for TREATMENT

In seeking medical care from Community Medical Clinic, I do hereby voluntarily consent to such examination and treatment as is deemed necessary by Community Medical Clinic. I understand the practice of medicine is not an exact science, and that diagnosis and treatment involve risks of injury or even death. I acknowledge that Community Medical Clinic providers have made no guarantees to me as a result of examination or treatment.

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

Do you have an Advance Directive? ☐ **yes** ☐ **no**

If no, would you like some information about Advance Directives? ☐ **yes** ☐ **no**

Patient Acknowledgement:

Cancellation of Appointments. I agree to schedule appointments for my treatment. I agree that I will call and cancel my appointment at least 24 hours prior to the appointment time, if cancellation is necessary. I understand that if I have three missed or cancelled appointments, I may be discharged from the Health Center practice.

No Call / No Show. I understand that missing 3 appointments within 12 months as a no call/no show **may** cause me to be discharged from the practice.

I understand that if I have any problems getting to my appointment, I can let Community Medical Clinic know in advance and they may be able to **help me with transportation**.

Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices.

Responsibility for Payment. For and in consideration of services rendered, or to be rendered, to the named patient, I or we, or either of us do hereby promise to pay Community Medical Clinic the full amount of all charges incurred. I/we understand that Community Medical Clinic will file commercial insurance as a courtesy. Community Medical Clinic will allow 30 days for the insurance to resolve the outstanding charges.

Patient / Representative Signature:_____ Date:_____

Co-Signature (if needed)_____ Date:_____

END PART A

Please continue to the next section, PART B.

PART B

VII. Your Health History

Do you have vision impairment? ☐ yes ☐ no
Do you have hearing impairment? ☐ yes ☐ no
Do you have trouble reading? ☐ yes ☐ no
Do you require treatment/medication for chronic pain? ☐ yes ☐ no
Have you ever had a heart catheterization? ☐ yes ☐ no If yes, when? _____
Have you ever had any arterial stents placed? ☐ yes ☐ no If yes, when? _____
Have you ever had a colonoscopy? ☐ yes ☐ no If yes, when? _____

Please List other physicians or health care providers that you currently see and why you see them.

Doctor / Provider	Condition / Reason you see them

VIII. Personal Habits / Social History:

Do you now or have you ever used tobacco? ☐ yes ☐ no
If yes, do /did you - ☐ smoke ☐ chew ☐ use both?
If you smoke or have smoked, how many packs per day? _____
Are you currently using tobacco? ☐ yes ☐ no
If no, when did you quit tobacco use? _____
How long did you smoke? _____months or years (circle one)?
How long did you dip/chew? _____ months or years (circle one?
Do you use or have you used E-cigs or Vaping? ☐ yes ☐ no
Have you ever used recreational / street drugs? ☐ yes ☐ no
If yes, what? _____When?_____
Do you regularly drink alcohol? ☐ yes ☐ no
If yes, what and how much on average? ☐ Beer -Number of bottles or cans per day _____
☐ Wine - Number of glasses per day _____ ☐ Liquor – Number of ounces per day_____

If yes, have you had 6 or more drinks during a drinking session in the past year? ☐ yes ☐ no

Has a person that you live with hit you or hurt you physically in the past? ☐ yes ☐ no
Has any person verbally abused you? ☐ yes ☐ no
Do you feel safe? ☐ yes ☐ no

IX. Immunization History:

Vaccination	Date of Immunization
Influenza	
Pneumonia	
Tetanus / Tdap	
Hepatitis B	
Shingles	

X. SELF and FAMILY HISTORY: **Do <u>you</u> or <u>any family members</u>** have, or have had, any of the following conditions? *(grandparents, parents, aunt, uncle, brother, sister or you) Check the appropriate answers, Y/N.*

Condition	Y	N	ME (if yes applies)	Family Member if yes applies	Condition	Y	N	ME (if yes applies)	Family Member if yes applies
Heart Attack					Migraines				
High Blood Pressure					Seizures				
Congestive Heart Failure					Melanoma (skin cancer)				
Rheumatic Heart Disease					Ovarian Cancer				
Congenital Heart Disease					Pancreatic Cancer				
Breast Cancer					Any other Cancer				
Colon Cancer					Tuberculosis				
Colitis					Diabetes				
Crohn's Disease					Goiter/ Thyroid Disorder				
Colon Polyps					Blood Clotting Disorders				
Hepatitis					Bleeding Tendency				
Stomach Ulcer					Anxiety and/or Depression				
Kidney Disease					Suicide				
Stroke					Mental Illness				
Leukemia					Drug or Alcohol Abuse				

XI. THE FOLLOWING SECTION IS FOR FEMALES ONLY :

Are you pregnant or could you be? ☐ **yes** ☐ **no** **Date of last menstrual period:**_____

Have you had a hysterectomy? ☐ **yes** ☐ **no** **If yes, when?** _____

Do you regularly have a PAP smear? ☐ **yes** ☐ **no** **Date of last test**_____

Have you had a mammogram? ☐ **yes** ☐ **no**

How many pregnancies have you had? _____ **Have you had a miscarriage?** ☐ **yes** ☐ **no**

How many vaginal births have you had?_____ **How many C-sections have you had?** _____

How many premature births?_____ **Any complications of pregnancy?** ☐ **yes** ☐ **no**

If yes, explain. _____

_____

MEDICATIONS List medications you are currently taking:

_____

_____

_____

_____

_____

ALLERGIES To medications or substances:

_____

_____

_____

_____

XII. What We Should Know.

THE FOLLOWING QUESTION IS FOR EVERYONE:

Is there anything that you think we need to know about you? If so, please tell us in the space below.

_____

_____

_____

_____

Thank you for Choosing

Community Medical Clinic!

Your Health is our First Priority