COMMUNITY MEDICAL CLINIC

NEW 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

Please review each section, check each box, and sign below.

☐ **1. Release of Medical Records**

I authorize Community Medical Clinic (CMC) to release my medical records, if needed, for referral to a specialist or outside provider for continuity of care. This excludes behavioral health, HIV/AIDS status, and substance abuse records unless a separate consent form is completed. CMC will refer me to my preferred provider when possible; if unavailable, a similar qualified specialist may be selected. This authorization remains valid until revoked in writing.

☐ **2. Consent for Treatment**

By seeking care at CMC, I consent to examinations and treatments deemed necessary by my provider. I understand that medical care involves risks, including possible injury or death, and acknowledge that no guarantees have been made regarding outcomes.

☐ **3. Appointment Scheduling & Cancellation**

I agree to schedule appointments for my care and will notify the clinic at least 24 hours in advance if I need to cancel.

☐ **4. No Call / No Show**

I understand that missing three (3) appointments within 12 months without notice may result in discharge from the practice.

☐ **5. Transportation Assistance**

I understand that if I have difficulty getting to an appointment, I may notify CMC, and transportation assistance may be available.

☐ **6. Notice of Privacy Practices**

I have received a copy of CMC's Notice of Privacy Practices.

☐ **7. Payment Responsibility**

I understand that co-pays, co-insurance, and sliding scale fees are due at the time of service.

_____ **Date:**_____

Patient Signature

*Patient Name:*_____ *Date of Birth:*_____

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 FPI 100% or below	Class B FPI 101%-125%	Class C FPI 126%-150%	Class D FPI 151%-200	Class E 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.

*Patient Name:*_____ *Date of Birth:*_____

Pennyroyal Healthcare Services, Inc DBA Community Medical Clinic

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following person(s) to receive my health information:(i.e spouse, parent, child or etc)

_____

To use or disclose the following health information: (check one)

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

II.Consent for HIV/AIDS

This medical record may contain information concerning **HIV Testing and/or AIDS diagnosis or treatment.**

☐ - I consent to have this information released.

☐ - I do not consent to have this information released

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

III. My Rights

- I may revoke this in writing anytime
- Revocation may not apply if used for insurance.
- Released info may be re-disclosed and not protected by HIPAA.
- Signing is not required for treatment (unless for third-party use/Research).
- I will receive a copy; copies are valid as originals.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ Patient is a minor: _____ years of age

Signature of Authorized Representative _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:_____

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

Part B

Medical History Form

Name:	Male ☐ Female ☐	DOB:
Previous Doctor:	Date of last physical Exam:	

Any Specialists You See:	Reason you see this Specialist

Medical Conditions you have been diagnosed with in the past:
Allergies to Medications or Substances:

Surgeries	Date/Hospital
Colonoscopy? Yes ☐ No ☐	Date of Most recent Colonoscopy:

Other Hospitalizations	Date/Hospital

List All Prescribed and Over the Counter Medications you take including vitamins and inhalers

Name of Drug	Strength	Frequency taken

Personal Habits/Social History		
Do you drink alcohol?	YES_____	NO_____
-If yes, how may drinks per week?		
- Are you concerned about the amount you drink?	Yes_____	No_____
- Have you considered stopping drinking?	YES_____	NO_____
Do you use tobacco?	Yes_____	No_____

Cigarettes ☐ #per day_____	Smokeless Tobacco ☐	Pipe ☐
Number of years smoked_____	Ready to Quit ( )	
Former Smoker Yes ◯ No ◯	Year Quit _____	

Do you currently use any recreational/street drugs?	Yes ◯	No ◯
Have you ever injected street drugs with a needle?	Yes ◯	No ◯
Are you sexually active?	Yes ◯	No ◯
Any concerns for STD or diseases such as HIV/AIDs?	Yes ◯	No ◯
Safety Concerns:	Yes ◯	No ◯
Do you live alone?	Yes ◯	No ◯
Do you have frequent Falls?	Yes ◯	No ◯
Do you have vision or hearing loss?	Yes ◯	No ◯
Do yo uhave an Advance Directive or Living Will?	Yes ◯	No ◯
Has anyone hit your or hurt you physically in the past ?	Yes ◯	No ◯
Has anyone verbally abused you?	Yes ◯	No ◯
Do you feel safe?	Yes ◯	No ◯

Immunizations:

Influenza vaccine Y ◯ N ◯ Date:	Pneumonia Vaccine Y ◯ N ◯ Date:
Tetanus/TDAP Y ◯ N ◯ Date:	Shingles Vaccine Y ◯ N ◯ Date:

Self and Family Medical History

List any Significant health problems such as diabetes, heart disease, stroke, COPD, Mental illness, Hypertension, cancer that your family members have had

Father:	Alive ◯ Deceased ◯
Mother:	Alive ◯ Deceased ◯
Children:	Alive ◯ Deceased ◯
Siblings:	Alive ◯ Deceased ◯
Maternal Grandmother:	Alive ◯ Deceased ◯
Maternal Grandfather:	Alive ◯ Deceased ◯
Paternal Grandmother:	Alive ◯ Deceased ◯
Paternal Grandfather:	Alive ◯ Deceased ◯

Women's Health- only applies to female patients

Are you pregnant or breastfeeding? Yes ◯ No ◯
Number of Pregnancies_____ Number of live births_____
Date of last menstrual period:_____
Date of last pap?_____
Date of last mammogram_____

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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