HOPE CLINIC
delivering hope & health

Pt.#: _____

Request for Services

Patient Name _____ _____
(First) (Middle) (Last)

Preferred Name (if any) _____ _____

Parent/Guardian's name (if applicable):_____ **Relationship to patient** ____ _____

Sex: □M □F **Date of Birth**: ____/____/____ **SSN**:____-____-_____ □□None
(mm) (dd) (yyyy)

Address _____ _____ □□None
Street City State Zip

Home Phone: (_____)_____ **Cell Phone:** (____)_____**Work Phone**:(_____) _____ _____

Email _____

Contact Preference (*please choose one*): □Home phone □Work phone □Mobile Phone □Mail

Do you give Hope Clinic consent to call you? □Yes □No **Do you give Hope Clinic consent to text you?** □Yes □No

Preferred Language: □English □Spanish □Other _____ **Need Translation:** □Yes □No

Race: □American Indian □Asian □Asian Indian □Black or African American □European □Filipino □Japanese □Korean
□Native Hawaiian or Other Pacific Islander □White □Decline to answer

Ethnicity: □Central American □Cuban □Dominican □Hispanic or Latino/Spanish □Mexican □Not Hispanic or Latino
□Puerto Rican □South American □Spaniard □Decline to answer

Marital Status: □Married □Single □Divorced □Separated □Widowed □Partner

How did you hear about Hope Clinic? □Advertising □Other Physician □Word of Mouth □Hope Clinic Patient
□Hospital □Church □Other: _____

Emergency Contact Name: _____ **Relationship** _____ _____

Emergency Contact Home Phone: (____)_____ **Emergency Contact Cell Phone**: (_____) _____ _____

What best describes your current employment status? □□Employed □□Unemployed □□Self-employed □□Retired □Other

If employed, please list employer name:_____Industry: _____

Do you currently have health insurance or participate in any medical assistance program? □□Yes □□No

If yes, which type? □□Medicaid □□Medicare □□Private health insurance □□CHIP □□Other ____ _____

What is/are the reason(s) for your visit? _____

_____

If you had not come to Hope Clinic today, where would you have gone to receive medical care? □Emergency Room
□Urgent Care □ Doctor's office □Other free clinic □Would not have received care

All medical records at Hope Clinic are stored electronically. Patients can access their medical records, send confidential messages to providers, request prescription refills, view test results and more through their online patient portal account. The patient portal is free and can be accessed through Hope Clinic's website at hopeclinicmckinney.org. Would you like for a Hope Clinic staff member to help set up your online account? ∆ **Yes** ∆ **No**

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Patient Agreement and Permission to Treat

Hope Clinic of McKinney is a non-profit agency. To better serve you, we ask for your cooperation in following the policies listed below. **These policies apply to both in-office and telehealth visits**. If you are unable to follow these guidelines, or find them unacceptable, another care provider may be better able to meet your needs.

PLEASE READ AND INITIAL EACH STATEMENT TO ACKNOWLEDGE AGREEMENT

Initials	Statement
	I understand that the examination and medical care given to me (or my minor child) will be provided by a licensed physician, physician assistant, or nurse practitioner.
	I authorize any health care professional associated with Hope Clinic to disclose any personal, evaluation, and/or treatment information to other health care professionals for continuation of care or for purposes of obtaining health care information from other facilities when medically necessary.
	I understand that Hope Clinic does not prescribe narcotics.
	If I am referred to another agency for assistance, I give my permission for pertinent information to be released to that agency. If Hope Clinic provides me with referrals, I agree there is no legal responsibility for services provided by other agencies.
	I understand that I am solely responsible for the follow-through on testing and/or treatment ordered by medical providers at Hope Clinic, and that if I fail to do so my treatment may be unsuccessful. I understand that I am expected to obtain any labs or imaging ordered by my physician prior to my next appointment.
	I understand that my medical records are available upon request by signing a medical records release form during clinic hours or through the Patient Portal.
	All information is treated as confidential and will be held in strict confidence, except as required by the law or the following circumstances: (1) when there is a reasonable suspicion of child abuse, whether the patient is the victim or the abuser, or when there is a threat of harm to a third party; (2) when there is a threat of self-inflicted harm; (3) when there is a reasonable suspicion of intimate partner violence; (4) when there is a threat against the clinic itself.
	I agree to inform Hope Clinic within 30 days of any change in my name, address, telephone number, household income, or if I have qualified for insurance of any kind by calling (469) 712-4246.
	I agree to complete the required annual re-enrollment process and provide my most current financial documents.
	I understand that if I miss three (3) appointments in one year, without calling to cancel or reschedule more than 24 hours in advance, you may not remain a Hope Clinic patient. I understand that I may leave a voicemail at (469) 712-4246 to cancel or reschedule my appointment. I understand that if I am more than 5 minutes late for my appointment, I am not guaranteed to be seen and may have to be rescheduled.
	I understand that video- or audio-taping of any portion of my visit, by any method or device, including cell phones, is strictly prohibited. I understand that Hope Clinic and its representatives (paid or volunteer) do not consent to having any conversations recorded.
	I understand that if I am uncooperative, verbally or physically abusive, intoxicated, or behave in an inappropriate manner, I may not be eligible for services at Hope Clinic.

I have read, understand, and agree to the guidelines set forth by Hope Clinic of McKinney. I understand that I can be denied further services provided by Hope Clinic of McKinney if I have given false or misleading information.

Patient Signature_____Date _____

Signature of Parent/Legal Guardian (if applicable): _____

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Notice of Privacy Practices

A laminated copy of Hope Clinic's Notice of Privacy Practices may be found at the back of your registration packet.

I,_____, have read and understand Hope Clinic of McKinney's Notice of Privacy Practices. I understand that if I have any questions I may contact Hope Clinic's Operations Manager, who is acting as the Privacy Official at (469) 712-4246. I understand that I may receive a copy of these notices if I request one.

_____ _____
Patient Name Date (mm/dd/yyyy)

_____
Patient Signature

_____
Parent/Legal Guardian Signature (if applicable)

FOR OFFICE USE ONLY	
We attempted to obtain written acknowledgement of the above stated legal notices, but acknowledgement could not be obtained because:	
	individual refused to sign the acknowledgement.
	communication barriers prevented obtaining the acknowledgement.
	an emergency situation prevented obtaining the acknowledgement.
	Other (please specify):
Screener Signature_____ Printed Name_____ Date _____	

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Free Clinic Federal Tort Claims Act (FTCA)
Patient Notice of Limited Liability

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practical, or to a parent or guardian when the patient lacks legal responsibility for his/her are under state law.

Notice to Patients

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer healthcare practitioners who have provided a regular or authorized service under Title XIX of Social Security Act. The legal liability of the deemed individual is limited pursuant to section 224(o) off the Public Health Service Act, 42 U.S.C. 233(o).

(i.e.: Medicaid program) at a free clinic site or through offsite programs or events carried out by a free clinic (See 42 U.S.C. § 233(a), (o)).

The above federal law may cover certain free clinic healthcare professionals providing health care services to patients at this free clinic.

CONSENT FOR CHARITY CARE

I, _____, acknowledge that the physicians of Hope Clinic of McKinney are volunteer health care providers and are not administrating care for or in expectation of compensation. I also understand that as volunteer health care providers, these physicians are immune from civil liability for any act or omission resulting in death, damage, or injury, as long as the volunteers act in good faith and in the scope of his or her duties within the organization in providing the health care services.

Furthermore, I realize that the civil liabilities of both the charitable organization and an employee of the charitable organization are limited to money. These limits apply to the employee and the organization separately; they are not aggregate limits.

Patient Signature: _____ Date: _____

Patient Name: _____

Parent/Legal Guardian Signature (if applicable: _____

Pt. #: _____

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Communication of Health Information

Communication with Patient

*Please choose **one** of the following for each method of communication*:

Home Phone:

☐ Hope Clinic may leave a message with detailed information

☐ Hope Clinic may leave a message with a call-back number only.

Cell Phone:

☐ Hope Clinic may leave a message with detailed information

☐ Hope Clinic may leave a message with a call-back number only.

Communication with Others

I hereby give permission to the staff of Hope Clinic of McKinney to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s), and/or close personal friends:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

☐ ☐ I do not wish to diclose any information with anyone.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require my specific authorization prior to the disclosure of medical information.

_____ _____

Signature of Patient Date

_____

Signature of Parent or Legal Guardian (if applicable)

Pt.#: _____

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Community Referral Form

We would like to know if there are any other difficulties, aside from your medical needs, that you or your family are currently experiencing. Our staff will go over this form with you to explore any appropriate referrals to the various social agencies in this community. All information you provide is strictly confidential, unless you authorize release of information. Please check the boxes below if you would like to talk to someone on our team about:

☐ Anxiety/Depression/Stress	☐ Recent Death/Loss/Grief	☐ Clothing/Food Pantry/Food Stamps
☐ Dental Services	☐ Vision/Eye Services	☐ Financial Assistance/Rent/Utilities
☐ Housing	☐ Immigration/Legal	☐ Job Training/Education/GED
☐ Mammogram/Pap Smear	☐ Medicaid/CHIP	☐ Nutrition/Exercise
☐ Parenting Needs	☐ Smoking/Drugs/Alcohol	☐ Transportation
☐ Domestic Violence/Abuse	☐ English Language Learning	☐ ☐ Other: _____

Please circle the answer that best describes your situation:

We have worried whether our food would run out before we got money to buy more in the last 12 months.	Often True	Sometimes True	Never True
The food we bought just didn't last, and we didn't have money to get more in the last 12 months.	Often True	Sometimes True	Never True

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Would you like for someone on our team to pray with you while you are at the clinic? ☐ ☐ Yes ☐ ☐ No

If you are comfortable doing so, please write your prayer request(s) below. This information is kept confidential and will not be shared outside our Hope Clinic prayer team.

_____

_____

_____

_____

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Patient Rights and Responsibilities

At Hope Clinic we believe in team-based health care. That means that we,as health care providers have an active role, and you, as a patient have an active role.

Hope Clinic is responsible for:

Providing evidence-based primary care services.
Providing considerate and respectful care.
Explaining all procedures and test results at patient appointments. Providing reasonable answers to questions at appointments.
Keeping all medical information private.

You, as a patient, are responsible for:

Being on time for appointments. If you must cancel or reschedule, you must call us at (469) 712-4246 at least 24 hours prior to the appointment time. Leaving a voicemail will constitute contact. If you miss three appointments in one year without calling to cancel or reschedule, Hope Clinic may discontinue care.

- As you are able, making a donation of any amount at each visit to help cover the costs associated with the care provided to the next patient.

Obtaining any lab testing or imaging that is ordered by your physician prior to your next appointment.

Informing Hope Clinic within 30 days of any change in your insurance status, income, or contact information. Failure to do so can result in delayed treatment.

- Timely providing updated patient enrollment documents (proof of residency and income) each year.
- Being an active partner in managing your health.

_____
Patient Name

_____
Patient Signature

_____
Date

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Medical Records Release

Patient Name: _____ DOB: _____

RELEASE FROM: _____

RELEASE TO: Hope Clinic, PO Box 2543 McKinney, TX 75070, (p) 469.712.4246

INFORMATION TO BE RELEASED: (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other:_____
☐ Discharge Summary ☐ Latest Labs ☐ Surgical Reports ☐ Imaging (past 2 yrs)
☐ Last Office Visit Progress Notes

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

4. **RECORDS FROM THE TIME PERIOD:** _____/_____/_____ through _____/_____/_____

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)
   ☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
   ☐ Personal ☐ Workers' Compensation Claim ☐ Other: _____

6. I understand that this authorization shall be valid for five years. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. The requestor may be provided with a copy of this authorization.

Patient/Guardian Signature: _____ Date: _____

For office use only:

_____

Pt# Date Signature of Staff Member Sending Request