Do Not Scan

HOPE CLINIC
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New Patient Enrollment Check-List

Must have all documentation in order to enroll

☐ **PHOTO ID**

☐ **PROOF OF ADDRESS**
Choose one:

_____ Address on ID

_____ Utility Bill or Lease

_____ Self Declaration

☐ **PROOF OF INCOME**
Choose one:

_____ Physical copy/copies

_____ Digital copy/copies emailed to **jenny@hopeclinicmckinney.org**
*Cannot complete enrollment process if clinic has not received email

_____ Self Declaration**
**Self declarations will not be accepted outside of Hope Clinic
(i.e. Imaging, RX assistance, etc will be self pay)

☐ **COMPLETED REGISTRATION PACKET**

OFFICE USE ONLY:

Applicant # _____

*No applications taken after 12:00PM

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New Patient Enrollment Packet PT#_____

Last Name _____

First Name_____

Preferred Name_____

Middle Name _____

Sex - Male / Female

DOB _____/_____/_____

SSN _____ - _____-_____ ☐ None

Address_____

City_____

State_____

Zip Code_____

Home Phone # _____

Mobile Phone # _____

Consent to Text Yes / No **Consent to Call** Yes / No

Email_____

Contact Preference *Choose one:*

Home **work**

Mobile **Mail**

Emergency Contact:

Name_____

Number_____

Relationship_____

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: *(please choose one)* Married Single Divorced Separated Widowed Partner

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New Patient Enrollment Packet PT#_____

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

How did you hear about Hope Clinic? __Advertising __Other Physician __Word of Mouth __Hope Clinic Patient __Hospital __Church
Other: _____

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

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? _____

_____

_____

_____

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New Patient Enrollment Packet PT#_____

PATIETNT AGREEMENT & 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

	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.		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.
	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.
	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 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 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 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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New Patient Enrollment Packet PT#_____

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)

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New Patient Enrollment Packet PT#_____

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 healthcare 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 acting 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: _____

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Communication of Health Information

Communication with Patient

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

Cell Phone	Yes / No	Home Phone	Yes / No
Hope Clinic may leave a message with DETAILED information		Hope Clinic may leave a message with DETAILED information	
Hope Clinic may leave a message with a call back number ONLY.		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 disclose 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)

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New Patient Enrollment Packet PT#_____

PatientRights 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

Pt #_____

If you think you may have a medical emergency while waiting for your appointment, call 911 or go to the nearest emergency room immediately. No physician-patient relationship or medical advice can be provided until you are seen at your first medical appointment.

Reason for Visit:

_____

_____

Preferred Pharmacy:

Name & Address _____

Allergies	Medications
Medications you are allergic to:	Please list medication and dose
_____	_____
_____	_____
Allergic to LATEX: Y / N	_____

Vaccines: Please circle Yes or No and provide dates.

Tetanus Y / N date: _____ Pneumonia Y / N date: _____

Flu Y / N date: _____ COVID-19 Y / N dates: _____

Past Medical History: Do you have Diabetes, heart disease, hypertension, Cancer? etc.

_____

_____

_____

Family History: Maternal / Paternal Diabetes, hypertension, caner? Etc.

_____

_____

_____

Pt #_____

Social History

Do you smoke? Yes or No

Former smoker? Yes or No

How Often? _____

When did you quit? _____

How many years? _____

Have you had a Lung CT? Yes or No

When? _____

Do you drink Alcohol? Yes or No

If yes, how many drinks per day or how often? _____

Have you used illicit drugs? Yes or No

If yes, when did you last use? _____

IV drugs? Yes or No

What type of drugs have you used? _____

Past Surgeries

Past Surgeries: Yes or No

If yes, List surgeries below with dates

_____

_____

Screening

Have you had a colonoscopy or any other form of colon cancer screening test? Yes or No

Result _____ Date: _____ Type of test? _____

Have you been tested for Hepatitis C? Yes or No

Result _____ Date_____

FEMALE

Date of your last:

Pap smear: _____ Abnormal Y or No

Mammogram_____ Abnormal Y or No

Male

Date of your last:

Prostate exam or Blood test:_____

Result:_____