Revised 02/07/2014

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last) (First) (Middle) (Jr.,Sr.,etc.)			
Date of Birth / /	**Gender** ☐ Female ☐ Male	**Social Security Number**	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated
Home Phone Number ( )	**Work Phone Number** ( ) ext.	**Cell Phone Number** ( )	**Email Address**
Full Address (Street or PO Box) Apt. #		(City)	(State) (Zip)
Who is your provider at CCHS?	**Employment Status** ☐ Full-Time ☐ Part-Time ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Active Duty ☐ Unemployed		Please be prepared to present your insurance card, photo identification & proof of income documentation, if necessary.

RESPONSIBLE PARTY Complete if different from above

Relation to Responsible Party ☐ Self ☐ Spouse ☐ Child ☐ Grandchild ☐ Foster Child ☐ Guardian ☐ Mother ☐ Father ☐ Other _____			
Name of Responsible Party (Last) (First) (Middle) (Jr.,Sr.,etc.)			
Date of Birth / /	**Gender** ☐ Female ☐ Male	**Social Security Number**	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated
Home Phone Number ( )	**Work Phone Number** ( ) ext.	**Cell Phone Number** ( )	**Email Address**
Full Address (Street or PO Box) Apt. #		(City)	(State) (Zip)

INSURANCE INFORMATION In uninsured, please be prepared to present proof of income to qualify for discount program

Primary Insurance (Carrier Name)		**Insurance Address**	**Phone Number** ( )	
Policy Holder ID (Subscriber ID)	**Group #**	**Subscriber Name**	**Relation to Subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Other_____	**Co-pay** ($)
Secondary Insurance (Carrier Name)		**Insurance Address**	**Phone Number** ( )	
Policy Holder ID (Subscriber ID)	**Group #**	**Subscriber Name**	**Relation to Subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Other_____	**Co-pay** ($)

If you have more than two insurances, please provide the additional information at the time of registration.

ADDITIONAL REQUIRED INFORMATION

What is your primary language? ☐ English ☐ Spanish ☐ Other_____	**Do you require translation?** ☐ Yes ☐ No	**Are you homeless?** ☐ Yes ☐ No
If homeless, what is your living situation? ☐ Shelter ☐ Transitional ☐ Staying w/ Family or Friends ☐ Street ☐ Other_____		**Are you a veteran?** ☐ Yes ☐ No
What is your race? ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Multiple Races ☐ Other_____	**What is your ethnicity?** ☐ Hispanic/Latino ☐ Not Hispanic/Latino	
Are you an agricultural worker? ☐ No ☐ Yes If yes, are you ☐ Migrant or ☐ Seasonal?	**How did you hear about First Refuge?** ☐ Friend/Family ☐ Health Fair ☐ Other_____	
How often are you paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually	**What is your gross income (before taxes) during this period?**	**How many individuals reside in your household?**
Emergency Contact (Name, Address, Phone Number)		**Relation to Patient**
Primary Pharmacy (Name, Address, Phone Number, and Fax)		

AUTHORIZATION & ASSIGNMENT

I do hereby voluntarily consent to medical care at First Refuge Ministries Medical Clinic (FRMMC). I hereby authorize all physicians and their assistants including Physician Assistants and Nurse Practitioners employed by FRMMC to use such diagnostic and treatment procedures they deem necessary for proper medical management and treatment. I understand that Physician Assistants and Nurse Practitioners are not licensed physicians and may provide medical care only under the supervision and direction of a licensed physician. I also assign the claim payments to be made payable to FRMMC. I agree to the release of information to Medicare, Medicaid, CHIPS, and third party payers. I understand that some services that may be ordered may not be covered under Medicare, Medicaid, CHIPS or third party payers and that I am responsible for any amount that is not paid. THIS AUTHORIZATION AND ASSIGNMENT IS A PERMANENT ONE-TIME SIGNATURE WHICH WILL REMAIN ON FILE AND WILL BE USED FOR FUTURE CLAIMS. I MAY REVOKE IT AT ANY TIME BY WRITTEN NOTICE.

Signature of Patient/Responsible Party: _____ **Date:** _____

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CHILD NEW PATIENT QUESTIONNAIRE

Mother's Name: _____ Age: _____
Occupation: _____
Father's Name: _____ Age: _____
Occupation: _____

Child's Name: _____
Child's Date of Birth: _____
Today's Date: _____

If adults in the household work outside the home, what childcare arrangements are made for this child? _____

PREGNANCY & BIRTH

1. Mother's age at the time of the child's birth _____
2. Did the mother have any illness during pregnancy? ☐ Yes ☐ No
3. Did she take any medications other than vitamins and iron? ☐ Yes ☐ No
4. Was the baby on time? ☐ Yes ☐ No
5. What was the birth weight? _____
6. Did the baby have trouble starting to breathe? ☐ Yes ☐ No
7. Did the baby have any trouble while in the hospital (jaundice, infections, other)? ☐ Yes ☐ No
   If yes, what kind _____

PAST MEDICAL HISTORY

1. Where has your child gone for check-ups before now? _____
2. Date of last check-up? _____
3. Date of last dental check-up? _____
4. Has your child had any allergic reactions to any medications, food, or insect bites ☐ Yes ☐ No
   Which ones? _____
5. Has your child had any reactions to any immunizations? ☐ Yes ☐ No
   Which ones? _____
6. Any hospitalizations other than for birth? ☐ Yes ☐ No
   For what? _____
7. Any serious injuries? ☐ Yes ☐ No
   What kind? _____
8. Are there any medications taken regularly? ☐ Yes ☐ No
   Which ones? _____
   _____

FAMILY HISTORY

1. Are the child's parents both in good health? ☐ Yes ☐ No
2. Check any diseases that this child's parents, grandparents, brothers, sisters, aunts or uncles have/had:
   ☐ Anemia ☐ Asthma ☐ Allergies ☐ Diabetes ☐ High Blood Pressure
   ☐ Heart Trouble ☐ Tuberculosis ☐ Mental Illness ☐ Drug Problems
   ☐ Inherited Illness ☐ Venereal Disease ☐ Cancer ☐ AIDS ☐ Others
3. List the age, sex and general health of brothers and sisters: _____
   _____
   _____
4. Have any of your children died? ☐ Yes ☐ No

FEEDING & NUTRITION

1. Is your child's appetite usually good? ☐ Yes ☐ No
2. Is it good now? ☐ Yes ☐ No
3. Was there severe colic or any unusual feeding problem during the first three months? ☐ Yes ☐ No
4. Do any foods disagree with him/her? ☐ Yes ☐ No
5. For the first six months is he/she (was he/she) breast fed or bottle fed? _____
6. If still on formula, which one do you use? _____

REVIEW OF SYSTEMS

1. Has your child had frequent ear infections? ☐ Yes ☐ No
2. Any eye problems? ☐ Yes ☐ No
3. Does he/she have frequent colds or sore throats? ☐ Yes ☐ No
4. Is there asthma, pneumonia or recurrent cough? ☐ Yes ☐ No
5. Does he/she have a heart murmur or problems? ☐ Yes ☐ No
6. .Any problems with urination? ☐ Yes ☐ No
7. Any problems with diarrhea or constipation? ☐ Yes ☐ No
8. Have there been any convulsions or other problems with his/her nervous system? ☐ Yes ☐ No
9. Any eczema, hives or other skin conditions? ☐ Yes ☐ No
10. Has your child ever been anemic? ☐ Yes ☐ No
11. List any medical problems? _____
    _____

DEVELOPMENT/BEHAVIOR

1. At what age did your child sit up alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1 1/2 years old? ☐ Yes ☐ No
4. How does this child compare to others his/her age? _____
   _____
5. Does he/she have any trouble sleeping? ☐ Yes ☐ No
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? ☐ Yes ☐ No
8. Does he/she get along with other children? ☐ Yes ☐ No
9. Check which, if any, your child has or does:
   ☐ Nail Biting ☐ Thumb Sucking ☐ Bed Wetting ☐ Bad Temper
   ☐ Problems w/ Toilet Training ☐ Hyperactivity ☐ Nightmares
   ☐ Speech Problems ☐ Problems w/ Discipline ☐ Others

SAFETY/ENVIRONMENT

1. We live in a (check one):
   ☐ Private House ☐ Apartment ☐ Mobile Home ☐ Other
2. Do you know the hottest water temperature in your pipes? ☐ Yes ☐ No
3. Is there a working smoke alarm on each floor? ☐ Yes ☐ No
4. Does your child always use a car seat/belt when riding in a car? ☐ Yes ☐ No
5. Are there any smokers in the household? ☐ Yes ☐ No
6. Are there any problems with the condition of your home (rats, paint peeling, mice, other)? ☐ Yes ☐ No
7. Does your child always wear a helmet when riding his/her bike? ☐ Yes ☐ No

IMMUNIZATIONS

1. Do you have a record of your child's immunizations? ☐ Yes ☐ No

Thank you for completing this form.

PATIENT'S CONSENT TO TREATMENT

By First Refuge Ministries Medical Clinic, 1701 Broadway St., Denton, TX 76201

I, _____ (self/parent/guardian), of _____ hereby consent(s) voluntarily to outpatient care encompassing diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (blood, urine, and other studies), heart tracing and administration of medications prescribed by the Physician, Physician's Assistant/Associate (PA) or Advanced Nurse Practitioner (ANP).

I further consent to the performance of minor surgery, mole removal, suturing, lacerations, etc. . . .

I further consent to photographs or x-rays necessary for diagnosis and for educational purposes.

I further consent to immunizations and/or screening exams to include: PPD skin test, influenza (flu) injections and/or Pneumococcal injections for myself, my child or person(s) I am assigned legal guardianship.

RELEASE OF INFORMATION:

I authorize the First Refuge Ministries Medical Clinic to release medical information to third party carriers for the purpose of filing insurance claims related to my medical care. I also authorize payment to the First Refuge Ministries Medical Clinic but not to exceed the customary charges for those services. I also authorize the First Refuge Medical Clinic to release information to other health care providers, child care providers, and/or federa,l and/or state health related agencies. I understand that information released may contain information on: immunization history and/or status, communicable diseases, sexually transmitted diseases, which may include but is not limited to: hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus (HIV) and known as acquired immune deficiency syndrome (AIDS), as well as information about drugs, alcohol, and sickle cell anemia (63 O.S. (B)). Payment history may also be released.

I understand that this consent form will be valid and remain in effect as long as I/we use First Refuge Ministries Medical Clinic, or until revoked in writing.

This form has been fully explained to me and I understand its contents.

Comments:

Signature of patient or person authorized to consent for patient: _____

Date: _____

Signature of person who explained the consent: _____

Date: _____

If the patient is a minor or is unable to give the consent, complete the following:

Patient is a minor _____ years of age.

Father: _____

Mother: _____

Patient is unable to give consent due to: _____

CONSENT TO TREATMENT BY VOLUNTEERS

I understand that services I receive from First Refuge Ministries Medical Clinic (FRMMC) may be provided by a volunteer, who is providing care that is not provided for or in expectation of compensation.

I further understand that Texas law imposes limits on the recovery of damages from such a volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act of omission resulting in death or injury to a patient if:

1. The volunteer was acting in good faith and in the course and scope of the volunteer's duties of functions within the organization.
2. The volunteer commits the act of omission in the course of providing health care services to the patient.
3. The services provided are with the scope of the license of the volunteer, and before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges:

   a) That the volunteer is providing care that is not administered for or in expectation of compensation; and

   b) The limitations of the recovery of damages from the volunteer in exchange for receiving the health care services.

I acknowledge that the health care providers, as volunteers, are providing me with care that is not administered for or in expectation of compensation, and in exchange for receiving the health care services, recovery of damages is limited.

( ) Myself
( ) The following person for whom I am legally responsible: _____

Signature of patient or person authorized to consent for patient: _____
Date: _____

Signature of screener: _____
Date: _____

PATIENT RESPONSIBILITIES

1. If you can not keep an appointment for any clinic service, you **MUST** call 940.222.4178 before the appointment time and tell the receptionist or leave a message on our phone system. This will not count against you if you call BEFORE your appointment time. Three missed appointments within a 6-month period without calling ahead will result in suspension of patient privileges at the clinic. Also, three consecutively missed appointments is grounds for dismissal from the clinic.

2. Every patient, NO EXCUSES, must update patient information each calendar year. This involves completing the paperwork and supplying the clinic with a copy of your current verification of income.

3. When you move or change telephone numbers, it is your responsibility to notify us by calling 940.222.4178. This will allow us to contact you when your medicine or lab results are ready.

4. Refills can only be ordered by calling us at 940.222.4178, 5 to 7 days ahead of the day you wish to pick up the medicine. Alternatively, your pharmacy may fax a refill request to us at 940.383.4455. Patient Assistance Program (PAP) medications not picked up within one month after patient notification that medications are in the office, will be canceled. Canceled PAP medications must be returned to the pharmaceutical company. If the patient requests the medication refill after the 30 days, the patient will be given a written prescription to be filled at the patient's expense at a pharmacy until medication can be reordered through the PAP and received at the clinic. **Medication cannot be filled before it is due to be refilled.**

5. Call 940.222.4178 to leave a message and you will be called back.

6. Patients are responsible for taking medication as ordered by the doctor. Patients may not skip doses, nor double doses, without doctor's written orders. Doing so puts your health at risk and will result in not getting refills when needed. If you have problems with your medication, call and leave a message for the nurse. She will talk with the nurse practitioner or director to see what needs to be done and will get back to you as soon as possible.

I have read and understand my responsibilities as a patient of the First Refuge Ministries Medical Clinic. I agree to comply with these requirements.

Signature of patient or person authorized to consent for patient: _____
Date: _____

Signature of witness: _____
Date: _____

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MISCONDUCT POLICY

First Refuge Ministries Medical Clinic (FRMMC) reserves the right to refuse service to patients that have conducted themselves in a manner that is considered inappropriate. Inappropriate behavior is defined as using foul language towards a member of the staff or another patient, being loud and disruptive in the waiting area, being intoxicated by drugs and/or alcohol, threatening any staff member or another patient, or harassing a staff member or another patient. These are examples of misconduct, and misconduct is not limited to these actions only.

I understand that if I should behave inappropriately, I will be warned, and could be dismissed from the clinic and will no longer be eligible to obtain services from FRMMC. I also understand that, depending on the severity of the incident, dismissal may be immediate. All incidents will be reviewed by a FRMMC physician and the clinic director.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

For Office Use Only:

MISCONDUCT WARNING

I understand that I have conducted myself in a manner deemed inappropriate by First Refuge Ministries Medical Clinic. I also understand that if I should behave inappropriately again, I will be dismissed from the clinic and will no longer be eligible to obtain services from First Refuge Ministries Medical Clinic. My questions were answered and I have received a copy of this policy.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

PATIENT REFUSED TO SIGN

Signature of Volunteer or Staff: _____ **Date:** _____

Comments:

PATIENT DISMISSAL POLICY ACKNOWLEDGMENT

First Refuge Ministries Medical Clinic (FRMMC) is a non-profit, no cost center for the purpose of ministering to the whole person—spirit, soul and body. Because of our limited mission statement and limited resources, we reserve the right to refuse to treat any patient.

1. If we do not have the resources to provide the perceived need of the patient, we can refuse to treat the patient.
2. If a patient is deemed to be uncooperative, overly aggressive, or behaviorally unmanageable, we can refuse to treat the patient.
3. If a patient is rude or uses profanity with clinic staff, we can refuse to treat the patient.
4. If a patient is a no-show for three consecutive appointments, we can refuse to treat the patient.
5. If a patient is found to be consistently untruthful, we can refuse to treat the patient.
6. If a patient is found to be dangerous to others, we can refuse to treat the patient.
7. If a patient is deemed to be beyond our scope of care, we can refuse to treat the patient.

By my signature, I acknowledge that I have read this patient dismissal policy, had the opportunity to ask questions and to discuss its content.

Patient Signature: _____ **Date:** _____

CLINIC POLICY ON DISCLOSURE OF HEALTH INFORMATION

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following categories describe the different ways that we use health information within First Refuge Ministries Medical Clinic (FRMMC) and disclose health information to persons and entities outside of FRMMC. Each description is of a category of uses or disclosures. We have not listed every use or disclosure within the categories, but all permitted uses and disclosures will fall within one of the following categories. Disclosure of health information will involve only the minimum necessary amount of information needed.

WITH WRITTEN CONSENT

In compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), we will obtain in writing, informed consent when patient first visits FRMMC. The information consent is necessary to allow us to use health information within FRMMC and to disclose health information outside of FRMMC.

Treatment: We may use health information about patient to provide patient with medical treatment and services. We may disclose health information to doctors, nurses, technicians, medical students, interns, or other personnel who are involved in treatment.

Payment: Although payment is not applicable for most services that FRMMC provides, HIPAA provides that we may use and disclose health information about a patient to an insurance company or third party for payment purposes.

Health Care Operations: We may use and disclose health information about patient for health care operations, including quality assurance activities; granting medical staff credentials to physicians; administrative activities, including FRMMC financial and business planning and development; and customer service activities, including investigation of complaints, etc. these uses and disclosures are necessary to operate our health care facility and make sure all of our patients receive quality care.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples of business associates include laboratory services, accreditation agencies, service consultants, quality assurance reviewers, etc. We may disclose health information to our business associates to sign an agreement that states they will appropriately safeguard information.

Appointment Reminders: We may use and disclose health information to contact patient or healthcare designee as a reminder of an appointment for treatment or medical care at our health care facility.

Drug & Alcohol Abuse: We will disclose drug and alcohol treatment information about patient only in accordance with the federal Privacy Act. In general, the Privacy Act requires written authorization for such disclosures.

Disclosure of Mental Health Information: We will disclose mental health treatment information about patient only in accordance with state law. In most cases, state law requires patient's written authorization or the written authorization of representative for such disclosures.

SPECIAL SITUATIONS THAT DO NOT REQUIRE INFORMED CONSENT OR AUTHORIZATION

The following disclosures of patient's health information are permitted by law without any oral or written permission from patient:

Organ or Tissue Donation: If patient is an organ donor, we may release health information to organizations that handle organ procurement, or organ, eye or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation or transplantation.

Military and Veterans: If patient is a member of the armed forces, we may release health information as required by military command authorities.

Worker's Compensation: We may release health information about patient for worker's compensation or similar programs if patient has a work injury.

Averting serious Threat: We may use and disclose health information about patient when necessary to prevent a serious threat to health or safety or the health and safety of another person or the public. These disclosures would be made only to someone able to help prevent the threat.

Public Health Activities: We may disclose health information for public health activities. These generally include the following:

1. To prevent or control disease, injury or disability
2. To report births and deaths
3. To report child abuse or neglect
4. To report reactions to medications, problems with products or other adverse events
5. To notify people of recalls of products they may be using
6. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
7. As authorized by law
8. To notify the appropriate government authority if we believe a patient has been the victim of abuse (including elder abuse), neglect or domestic violence

Health Oversight Activities: We may disclose a health information to health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If patient is involved in a lawsuit or dispute, we may disclose health information in response to a court or administrative order. We may disclose health information in response to a subpoena; discovery request or other lawful process by someone else involved in the dispute. We would only disclose this information if efforts have been made to tell patient about the request to allow patient to obtain an order protecting the information requested.

Law Enforcement: We may disclose health information if asked to do so by law enforcement officials for the following reasons:

1. In response to a court order, subpoena, warrant, summons or similar process
2. To identify or locate a suspect, fugitive, material witness or missing person
3. About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement
4. About a death we believe may be the result of a criminal conduct
5. About criminal conduct at our facility
6. In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security: We may disclose health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Inmates: If patient is an inmate of a correctional institution or under custody of a law enforcement official, we may disclose health information to the correctional institution to provide patient with health care, to protect health and safety and the health and safety of others or for the safety and security of the correctional institution.

Required By Law: We will disclose health information about patient without their permission when required to do so by federal, state or local law.

I have read this clinic policy on disclosure of health information, had the opportunity to ask questions, understand it, and agree to abide by these policies.

Patient Signature: _____ Date: _____

Printed Name: _____

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SCREENING QUESTIONNAIRE

SPIRITUAL SCREEN

Do you have any spiritual, cultural, or ethnic beliefs/practices that we should be aware of? ☐ Yes ☐ No If yes, please describe:
Would you like someone to pray with you today? ☐ Yes ☐ No
Would you like some information about a church in the area today? ☐ Yes ☐ No If yes, what faith?:

ABUSE/NEGLECT SCREEN

Have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid? ☐ Yes ☐ No
Have you ever been hurt, kicked, slapped, or pushed by your spouse or anyone close to you? ☐ Yes ☐ No
Behavioral clues of potential abuse (check all that apply): ☐ Defensive ☐ Evasive ☐ Listless/depressed ☐ Withdraws from touch ☐ Poor eye contact ☐ Frequent injuries ☐ Abnormally frightened

NUTRITION SCREEN

Check all the following that apply to the patient: ☐ No nutritional risk ☐ Skips meals ☐ Eats frequent high calorie snacks
How many servings of vegetables do you eat per day?
How many servings of fruit do you eat per day?
How many glasses of water do you drink per day?

FUNCTIONAL SCREEN

Check which applies to the patient: ☐ Ambulatory ☐ Non-Ambulatory ☐ Wheelchair Comments:

PAIN SCREEN

Pain level (0-10):	**Duration of Pain:**
Location of Pain:	**Medication/treatments used to alleviate pain:**

LEARNING ASSESSMENT

What are barriers to learning you might have: ☐ Unable to read ☐ Language ☐ Sight ☐ Hearing ☐ Cultural/religion ☐ Mental Status Explain:
How do you best learn? ☐ Explanation ☐ Demonstration ☐ Listening ☐ Handout ☐ Other:
How did you hear about us?

Notes:_____

_____

_____

Reviewed/Completed by: _____ **Date:**_____