ATTENTION NEW PATIENTS!

HARMONY HEALTH CLINIC 501-375-4400
New Patient Application Requirements

Applications must be returned COMPLETED with ALL documentation before an appointment can be made. Return this application Monday- Friday between 9 am-1 pm.

Requirements:

*You must live or work in Pulaski County.
*Your income is below 200% of the poverty level.
*No insurance is necessary to be seen.

Please bring the following to complete your new patient application:

1) Picture ID
2) Proof of residence
   - If your current address is different than the address on your ID, please bring a utility bill with your name and address.
   - If you are currently staying in a shelter, please bring a letter from the shelter confirming that you are staying there.
3) Proof of income
4) If you have been denied by Medicaid, please bring the denial letter.
5) Bring a copy of your 2014 Federal Tax return if filed; if not, complete the form 4506T included in the application.

If EMPLOYED, please bring:

- Current tax return
- One month of pay stubs

If UNEMPLOYED, bring any and all of the following that apply to you:

- Current social security/benefit letter
- SSI award letter
- Food Stamps award letter
- Unemployment statement
- Retirement/pension award letter
- Veterans benefit award letter
- Child support for each child
- Self employed income verification (bank statement)
- TEA/TANF award letter
- DHHS statement
- Other household income-identify source of income
- If you are living with someone who is take care of your necessities, that individual must sign the last page of the application and provide a utility bill with his/her name and address.
Today's Date: ____/____/______

Harmony Health Clinic
201 E. Roosevelt Rd, Little Rock, AR 72206
Phone: (501) 375-4400 Fax: (501) 375-4401

<table>
<thead>
<tr>
<th>Patient Information</th>
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<tbody>
<tr>
<td>Name</td>
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<tr>
<td>Address</td>
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<tr>
<td>City</td>
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<tr>
<td>Zip Code</td>
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<td>Gender</td>
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<td>State</td>
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<td>AR</td>
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<td>SSN#</td>
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<td>Date of Birth</td>
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<td>Emergency Contact Information</td>
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<tr>
<td>Name</td>
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<tr>
<td>Relationship to Patient</td>
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<tr>
<td>Cell phone</td>
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<tr>
<td>Home phone</td>
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</tbody>
</table>

Race/Ethnicity- Check all that apply
- [ ] White/Caucasian
- [ ] Black/African American
- [ ] Hispanic
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Native Hawaiian or other Pacific Islander
- [ ] Other

Marital Status
- [ ] Single
- [ ] Married
- [ ] Widowed
- [ ] Divorced
- [ ] Separated

Are you a legal resident?
- [ ] Yes
- [ ] No

Do you need the services of an interpreter?
- [ ] Yes
- [ ] No

Employment
- [ ] Full time
- [ ] Part-time
- [ ] Retired
- [ ] Disabled
- [ ] Unemployed

Did you or someone in your household file a tax return for last year?
- [ ] Yes/Si
- [ ] No

Do you have health insurance?
- [ ] Yes
- [ ] No

If yes, what type of insurance?

Have you been denied Medicaid?
- [ ] Yes
- [ ] No

Do you have any cultural or religious beliefs we need to be aware of in providing your care?
- [ ] Yes
- [ ] No

What brings you in to see the doctor or dentist?

Signature: __________________ Date: ____/____/______

Page 1
MEDICAL HISTORY
How would you rate your overall physical health?
☐ Very Poor  ☐ Poor  ☐ Average  ☐ Good  ☐ Very Good

Please list any major surgeries and dates of surgeries below.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please list any medications you are currently taking and dosage instructions below.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please list any allergies below.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

SUBSTANCE HISTORY

Do you drink alcohol?  ☐ Yes  ☐ No

If yes: how much and how often?

Do you use tobacco/nicotine?  ☐ Never
☐ Previously but not currently
   Date quit: ___/____
☐ Currently

If you currently use tobacco/nicotine, what type do you use and how often?

________________________________________________________________________

Do you use illegal, recreational, or street drugs?  ☐ Yes/Si  ☐ No

If yes: what type and how often?

________________________________________________________________________

FOR WOMEN ONLY

Age at first period: ________  # of pregnancies: ________  # of live births: ________

Are you on birth control? ________  Are you nursing? ________

Are you pregnant? ________

Date of last mammogram: ________  Date of last Pap smear: ________  Are you nursing? ________

Signature: __________________________ Date: ___/____/______

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**PERSONAL HEALTH HISTORY**

Have you had, or do you currently have, any of the following conditions? Check all that apply.

<table>
<thead>
<tr>
<th>Conditions</th>
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<tbody>
<tr>
<td>AIDS/HIV Positive</td>
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<tr>
<td>Alzheimer's Disease</td>
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<td>Anaphylaxis</td>
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<td>Anemia</td>
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<tr>
<td>Arthritis/Gout</td>
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<tr>
<td>Artificial Heart Valve</td>
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<td>Artificial Joint</td>
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<td>Asthma</td>
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<tr>
<td>Blood Disease</td>
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<td>Blood Transfusion</td>
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<tr>
<td>Breathing Problem</td>
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<tr>
<td>Bruise Easily</td>
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<tr>
<td>Cancer</td>
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<td>Chemotherapy</td>
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<td>Chest pains</td>
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<td>Cold Sores/Fever Blisters</td>
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<tr>
<td>Congenital Heart Disorder</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Drug Addiction</td>
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<tr>
<td>Easily Winded</td>
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<tr>
<td>Emphysema</td>
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<tr>
<td>Epilepsy or Seizures</td>
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<tr>
<td>Excessive Bleeding</td>
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<td>Excessive Thirst</td>
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<tr>
<td>Fainting Spells/Dizziness</td>
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<tr>
<td>Frequent Cough</td>
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<td>Frequent Diarrhea</td>
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<td>Frequent Headaches</td>
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<tr>
<td>Genital Herpes</td>
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<td>Glaucoma</td>
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<td>Hay Fever</td>
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<tr>
<td>Heart Attack/Failure</td>
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<td>Heart Murmur</td>
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<td>Heart Pacemaker</td>
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<tr>
<td>Heart Trouble/Disease</td>
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<td>Hemophilia</td>
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<td>Hepatitis</td>
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<td>Herpes</td>
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<td>High Blood Pressure</td>
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<td>High Cholesterol</td>
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<td>Hives or Rash</td>
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<tr>
<td>Hypoglycemia</td>
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<td>Irregular Heartbeat</td>
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<td>Kidney Problems</td>
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<td>Leukemia</td>
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<td>Liver Disease</td>
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<td>Low Blood Pressure</td>
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<td>Lung Disease</td>
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<td>Mitral Valve Prolapse</td>
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<td>Osteoporosis</td>
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<td>Parathyroid Disease</td>
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<td>Psychiatric Care</td>
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<tr>
<td>Radiation Treatments</td>
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<tr>
<td>Recent Weight Loss</td>
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<tr>
<td>Rheumatic Fever</td>
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<tr>
<td>Rheumatism</td>
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<td>Scarlet Fever</td>
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<td>Shingles</td>
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<td>Sinus Trouble</td>
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<td>Spina Bifida</td>
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<td>Stomach/Intestinal Disease</td>
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<tr>
<td>Stroke</td>
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<td>Swelling of Limbs</td>
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<tr>
<td>Thyroid Disease</td>
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<td>Tonsillitis</td>
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<td>Tuberculosis</td>
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<td>Tumors or Growths</td>
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<td>Ulcers</td>
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<td>Venereal Disease</td>
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<td>Yellow Jaundice</td>
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**MENTAL HEALTH ASSESSMENT**

Are you currently experiencing emotional difficulty? Please explain.

__________________________________________________________________________

On a scale of 1 to 10, with 10 being extremely stressed, how would you rate your current level of stress?  _____

Have you been treated for mental health issues in the past?  ☐ Yes  ☐ No

If yes, please explain prior treatment/diagnosis.

__________________________________________________________________________

Signature: ______________________  Date: ____/____/____
MENTAL HEALTH ASSESSMENT (cont.)
Please check all symptoms that currently apply.

☐ Crying Spells
☐ Low self-esteem
☐ Concentration loss
☐ Relationship Issues
☐ Appetite increase
☐ Problems at school/work
☐ Anxiety
☐ Special beliefs (ESP)
☐ Past traumatic events
☐ Mood swings
☐ Strong fears
☐ Impulsive
☐ Excessive sleep
☐ Increased energy

☐ Loss of patience
☐ High sexual interest
☐ Reliving trauma
☐ Excessive washing
☐ Fatigue
☐ Low motivation
☐ Memory loss
☐ Trouble sleeping
☐ Loss of enjoyment
☐ Thoughts of hurting others
☐ Addictions
☐ Inability to relax
☐ Making careless mistakes
☐ Paranoia

☐ Binge eating
☐ Self-injury
☐ Irritable
☐ Feeling worthless
☐ Forgetful
☐ Inappropriate behavior
☐ Avoiding activities
☐ Obsessive thoughts
☐ Hearing voices
☐ Loss of interest in hygiene
☐ Nightmares
☐ Suicidal thoughts
☐ Trouble keeping jobs
☐ Flashbacks

☐ Reckless behavior
☐ Panic attacks
☐ Rage/Anger
☐ Compulsions
☐ Confusion
☐ Hallucinations
☐ Appetite decrease
☐ Easily distracted
☐ Racing thoughts
☐ Making risky decisions
☐ Need things in order

FOR DENTAL PATIENTS ONLY- Fill out below

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician’s care now?  Yes/ Si  ☐ No

Have you ever been hospitalized or had a major operation?  Yes/ Si  ☐ No

Have you ever had a serious head or neck injury?  Yes/ Si  ☐ No

Are you taking any medications, pills, or drugs?  Yes/ Si  ☐ No

Do you take, or have you ever taken, Phen-Fen or Redux?  Yes/ Si  ☐ No

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing biphosphonates?  Yes/ Si  ☐ No

Are you on a special diet?  Yes/ Si  ☐ No

Do you use tobacco?  Yes/ Si  ☐ No

Do you use controlled substances?  Yes/ Si  ☐ No

Are you allergic to any of the following?

☐ Aspirin  ☐ Penicillin  ☐ Codeine  ☐ Local Anesthetics
☐ Acrylic  ☐ Metal  ☐ Latex/  ☐ Sulfur Drugs

Signature: __________________________  Date: ______/______/_______
Harmony Health Clinic
201 E. Roosevelt Rd, Little Rock, AR 72206
Phone: (501) 375-4400 Fax: (501) 375-4401

Today’s Date: __/__/____

Medical and Dental Consent

I give my consent to participate in the Medical and Dental programs provided by the Harmony Health Clinic. To the best of my knowledge, I have answered the above questions truthfully.

Signed: ___________________________ Date: __/__/____

Disability Claims Acknowledgement

I understand that Harmony Health Clinic does NOT treat patients for work-related illnesses or injuries and will not perform assessments for disability claims.

Signed: ___________________________ Date: __/__/____

Patient Compliance Acknowledgement

I understand as a patient of Harmony Health Clinic I must take responsibility for not missing scheduled appointments. I understand that it’s important for me to keep my appointments to allow staff to monitor my health and medications through a physician’s recommended treatment plan. After 3 missed appointments, I will be referred to a different clinic for treatment. If I call to cancel or reschedule the appointment at least 24 in advance of the appointment date, it will not be counted against me.

It is my understanding that after 3 missed appointments, I will no longer be eligible to receive medical or dental services at Harmony Health Clinic.

Signed: ___________________________ Date: __/__/____

Notice of Privacy Practices: Acknowledgment of receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Harmony Health Clinic. Our Notice provides information about how we may use or disclose your Protected Health Information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by visiting our website as www.harmonyclinicar.org or calling us at (501) 375-4400. If you have additional questions regarding the Notice of Privacy Practices, please contact the Privacy Officer at (501) 375-4400.

Printed Name: ___________________________

Signed: ___________________________ Date: __/__/____

Inability of patient to complete the preceding Acknowledgements

This section is to be completed by Harmony Health Clinic representative ONLY if no patient signature is obtained on above acknowledgements. Describe the good faith efforts made to obtain the acknowledgment.

Check the applicable reason for lack of signature or explain additional reason below:

_____ The patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given a copy of the Notice of Privacy Practices.

Other reason(s): _______________________________________________________________

Signature: ___________________________ Date: __/__/____

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Patient Authorization

I hereby authorize Harmony Health Clinic (HHC) and its employees and/or volunteers to use and disclose my individually identifiable health information as described below.

Information to be used or disclosed: My complete medical record for all dates of service, including but not limited to, patient intake forms; financial, household, and housing information; authorizations; consents; history and physical exam; progress notes; laboratory reports; diagnostic reports, healthcare records in my file from other healthcare providers; prescription records; and therapy records.

Person(s) authorized to receive my information: Any drug assistance or patient assistance program that offers prescription drugs, equipment, or supplies that I may be eligible to receive.

Purpose of use or disclosure: To apply for and receive prescription drug or other patient assistance.

Expiration: This authorization will expire upon termination of my treatment relationship with HHC.

I hereby authorize Harmony Health Clinic (HHC) to request my medical records, medical history, prescription drug information, and other health related information from another clinic or health provider should the physician deem that information necessary for the treatment of the patient while at Harmony Health Clinic.

Please initial below.

___ I understand that I may revoke this authorization at any time by providing written notice to Harmony Health Clinic’s Privacy Officer at 201 E. Roosevelt Rd, Little Rock, AR 72206 or via fax at (501) 375-4401. I further understand that any such revocation will not affect any use or disclosure made by HHC prior to its receipt of my written revocation.

___ I understand that HHC may not condition treatment on whether I sign this authorization.

___ I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, in which case my health information will no longer be protected by provisions of federal law governing the privacy of my individually identifiable health information.

___ I understand that HHC and its volunteers and staff may request information pertaining to my medical history from other health care providers when necessary.

Patient Drug Assistance Program Agreement

Appointment of HHC as Agent

I hereby authorize Harmony Health Clinic (HHC) and any HHC employee or volunteer with authority to sign applications, to act as my agent for purposes of applying for prescription drug or other patient assistance; receive prescription drugs, medical supplies, or equipment on my behalf; and take any other actions necessary to secure prescription drug or other patient assistance for me.

Accuracy of Information Provided

I hereby affirm that all information I have provided to Harmony Health Clinic for purposes of determining my eligibility for services from HHC and from prescription drug and other assistance programs is true and correct in all material respects. I authorize HHC to verify any information I have provided. I agree to notify HHC within ten (10) days if I obtain health insurance; if I become qualified for Medicare, Medicaid, or other federally funded health coverage; or if my financial situation improves such that I may become ineligible to receive services from HHC.

______________________________
Signature of patient or personal representative

______________________________
Date

______________________________
Relationship to patient

Signature: ____________________ Date: _____/____/_____

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Patient Notice of Volunteer Health Professional Immunity

The purpose of this notice is to inform you of state and federal laws that may affect your ability to sue volunteer health professionals who provide health care services to you at Harmony Health Clinic (HHC) to malpractice. Volunteer health care professionals who provide services to you at HHC may be covered by the state and federal laws described in this notice.

HHC is registered as a free or low cost health care clinic in accordance with Ark. Code Ann. Section 16-6-201 et seq. and related regulations issued by the Arkansas Department of Health. Meaning that any volunteer health care professional who renders health care services to you at HHC shall not be liable for any civil damages for any act or omission resulting from the rendering of health care services to you, unless the act or omission was the result of the health care professional's gross negligence or willful misconduct.

A federal low relating to the operation of free clinics known as the Federal Tort Claims Act (FTCA) 28 U.S.C. Section 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 HHC volunteer health care practitioner who the United States Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA who have provided a required or authorized service under Title XIX of the Social Security Act (i.e. Medicaid) at a free clinic site or though offsite programs or events carried out by the free clinic. See U.S.C. Section 233(a), (o).

Please note that HHC does not accept Medicaid-eligible patients or receive Medicaid Reimbursement for any services provided.

Acknowledged:

Signed: ____________________________ Date: ___/___/_____

Permission to Use my Photograph

Subject: Clinic in operation Location: Harmony Clinic

I grant to Harmony Clinic, its representatives, and employees the right to take photographs of me and my property in connection with the above-identified subject. I authorize Harmony Clinic, its assigns, and transferees to copyright, use, and publish the same in print and/or electronically.

I agree that Harmony Clinic may use such photographs of me with or without my name and for any lawful purpose, including for example for purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature: ____________________________ Printed Name: ____________________________

Address: __________________________________________

Date: ___/___/_____

DOB: ___/___/_____

Signature: ____________________________ Date: ___/___/_____

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Letter if you live within someone taking caring of your necessities

To whom it may concern,

At the present time, ___________________________ (patient’s name) lives with me at ___________________________.

(current address)

He/she is unemployed, and I assist him/her with his/her necessities and expenses.

Print name: ___________________________

Signed: ___________________________

The individual signing this statement must attach a utility bill showing his/her name and address.

Signature: ___________________________ Date: _____ / _____ / _____

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