PLEASE BRING TO YOUR FIRST VISIT

- PHOTO ID
- PROVIDE ONE OF THE FOLLOWING ITEMS WHICH SHOW PROOF OF INCOME

  PREVIOUS YEAR'S TAX RETURN
  W2
  1099
  TWO RECENT PAY STUBS OR THOSE FROM YOUR LAST EMPLOYER
  SOCIAL SECURITY INCOME STATEMENT SHOWING YOUR PAST YEAR'S INCOME (CAN BE OBTAINED AT THE SOCIAL SECURITY OFFICE)

- **ALL CURRENT MEDICATIONS AND SUPPLEMENTS IN THEIR ORIGINAL BOTTLES. FAILURE TO DO SO WILL RESULT IN THE RESCHEDULING OF YOUR APPOINTMENT.**

IF YOU ARE UNEMPLOYED, YOU MUST COMPLETE A NO-INCOME STATEMENT AND THE PERSON/PERSONS WHO PROVIDE YOUR FINANCIAL SUPPORT MUST COMPLETE A NOTARIZED STATEMENT. ***IF YOU ARE CURRENTLY RESIDING IN A SHELTER, THE FINANCIAL SUPPORT STATEMENT MAY BE COMPLETED BY AN ADMINISTRATOR.

HEALING HANDS COMMUNITY CLINIC REGISTRATION FORM

PLEASE PRINT AND COMPLETE ALL SECTIONS BELOW.

PATIENT'S PERSONAL INFORMATION:

NAME:_____DATE:_____

SSN:_____DATE OF BIRTH_____MARITAL STATUS: S M D W

STREET/MAILING ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL:_____

EMAIL ADRESS:_____

SPOUSE/PARENT NAME:_____

EMPLOYER:_____

WORK PHONE:_____DO YOU HAVE HEALTH INSURANCE?____

GROSS INCOME (BEFORE TAXES):
FOR THE PAST MONTH:_____YEAR:_____

NUMBER OF PEOPLE IN HOUSEHOLD:_____ADULTS:_____CHILDREN:_____

EMERGENCY CONTACT INFORMATION:

NAME OF PERSON NOT LIVING WITH YOU:_____

RELATIONSHIP:_____

PHONE NUMBER:_____

TODAY'S DATE: ____/____/_____

PATIENTS NAME: _____ **Date of Birth** ____/____/____

MEDICAL HISTORY

List all allergies and reactions

List all current medications, including vitamins, herbs, and those taken without a prescription:
Please list mg of each medication and how often you take the medication.

Please all of the physicians that you currently see:

Please list past surgeries and hospitalizations:

Please check if your mother, father, grandparents or siblings have or have had any of the following:

	Heart Disease		Seizures
	High Blood Pressure		Bleeding Disorder
	Stroke		Kidney Disease
	Cancer		Thyroid Disease
	Glaucoma		Mental Illness
	Diabetes		Arthritis
	Other:		Other:

Please check if you have or have had any of the following:

	Ring in the Ear		Peptic Ulcers		Seizures
	Ear Infection		Abdominal Pain		Stroke
	Dizziness/Faint		Gall Bladder		Tremor
	Hair Loss		Hepatitis		Muscle Weakness
	Failing Vision		Bowel Change		Numbness/Tingling
	Eye Infection		Headaches		Noew Bleeds
	Crohn's/Colitis		Arthritis		Sinus Trouble
	Bloody Stools		Osteoporosis		Hemorrhoids
	Sore Throat		Hernia		Bone Fracture
	Pneumonia		Urinary Infection		Gout
	Bronchitis/Cough		Blood in Urine		Foot Pain/Cold/Numbness
	Asthma/Wheezing		Rash/Hives		Chest Pain
	Psoriasis/Eczemia		Anxiety		High Blood Pressure
	Depression		Heart Murmur		Arrhythmia
	Kidney Stones		Memory Loss		Swollen Ankle
	Veneral Disease		HIV/AIDS		Varicose Veins/Phlebitiss
	Chronic Fatigue		Loss of Appetite		Recent Weight Loss
	Anemia		Prostrate Disease		Difficulty Swallowing
	Cancer		Indigestion		Diabetes
	Thyroid Disease		Persistent Nausea/Vomiting		

Please list last date for:

Tetanus Vaccine		Chest X-Ray	
Flu Vaccine		Labwork	
Hepatitis Vaccine		Colonoscopy	
Pheumonia Vaccine			

FEMALES: Please list last date for:

Pap Smear		Birth Control Type	
Abnormal Pap		Hormone Therapy	
Mammogram		Are You Pregnant	
Last Period			

MALES: Please list last date for:

PSA		Prostrate Exam	

USE OF:	TYPE:	HOW MUCH:	HOW LONG:
Tobacco Products			
Alcohol			
Illegal/Recreational Drugs			

CONSENT FOR TREATMENT

Healing Hands Community Clinic collects health information from you and stores it in written and electronic format. This is your health information. The health information is the property of Healing Hands Community Clinic, but the information is accessible to you. Healing Hands Community Clinic protects the privacy of your health information. The law permits Healing Hands Community Clinic to use or disclose your health information for the following purposes:
Treatment: Your health information can be used or disclosed by Healing Hands Community Clinic to enable Healing Hands Community Clinic to provide you with treatment.
Operations-Your health information can be used or disclosed for operational purposes.
Personal Use-Your health information can be disclosed to you.
Once you sign this consent form, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time (in writing), except to the extent that we have already relied on it. To revoke your written consent, please write to Healing Hands Community Clinic.

I hereby authorize Healing Hands Community Clinic staff:

To access information from my health history and records.

To administer and perform any medical examinations, treatments, or diagnostic procedures deemed necessary

To administer injections and perform venipuncture related to my health

To provide me a medical note upon request, if appropriate. This note will include my name, the date of visit, or other information.

In addition, I understand:

I may be asked to give specific consent for certain medical procedures.

I have the right to refuse diagnostic or treatment services, or to revoke this consent.

Any information, which is part of my medical record at Healing Hands Community Clinic, will be treated with the strictest confidentiality.

These include:

1. Reportable conditions, such as meningitis, TB and specific STD's.
2. Threat of immediate danger to self or others, such as suicide or homicide.
3. Any incidence of suspected elder or child abuse, neglect, or maltreatment.
4. In legal cases, the court may subpoena clinicians or clinic records.

I also understand that in the event of a medical emergency, information necessary to provide appropriate treatment may be disclosed.
By signing this consent form, I am acknowledging that I have read and understood the above material regarding Healing Hands Community Clinic procedures. I hereby authorize Healing Hands Community Clinic and its medical staff to use and disclose my personal health information, as necessary, for the purposes of obtaining medical treatment and for normal business operations.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

to be filed in Patient's Medical Records

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____ _____

Signature of Patient/Parent Date of Birth

_____

Relationship, if not signed by patient

INTERNAL USE ONLY

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date/time): _____

By (Name/Title) _____

Comments/Instructions:

HEALING HANDS COMMUNITY CLINIC
PATIENT-CLINIC RESPONSIBILITIES

1. I understand that Healing Hands Community Clinic is a non profit organization funded solely by community donations providing me free access to medical services. I also understand that I have the opportunity to assist the clinic through my personal donations at appointment times. Donation boxes are at the front desk and in the exam rooms.

2. Healing Hands Community Clinic is for residents of the tri-state mountain area who have no insurance, and who cannot afford to go to the doctor and obtain medical care. I confirm that none of the information regarding my finances has been falsified on my application.

3. Should I get insurance, it is my responsibility to inform Healing Hands Community Clinic and seek medical care elsewhere. I understand that I must report any changes of income to determine continued eligibility at the clinic.

4. I understand that appointment times are valuable and I must make every effort to keep my appointments, as scheduled. Please notify us 24 hours prior to your appointment if you will not be able to make it, otherwise it will be counted as a broken appointment. If you do not show for your 1st appointment, you will not be able to be seen as a patient, and will not be eligible to re-apply for one year. Should you miss three scheduled appointments (no shows), you will be automatically discharged as a patient from Healing Hands Community Clinic and not be eligible to re-apply again.

5. I understand that the clinic doctors and nurses take the responsibility of providing me with medical care to the best of their ability, very seriously. I understand that I may have to wait for another appointment, due to the limited physician schedule.

6. I understand that it is my responsibility to cooperate in my medical treatment to improve my health. This may include stopping smoking/alcohol, losing weight, exercising, taking medication as instructed, keeping scheduled appointments and other instructions the doctor may give me. If I make no effort in my own health actions, I may be discharged from the clinic.

7. I understand that the people who work in the clinic are volunteering and not being paid for their time. I also understand they are here because they share the vision of Healing Hands Community Clinic and choose to be here to help me. I promise not to be rude to any staff but treat them with respect and dignity. Rudeness to any staff member may cause you to be discharged from the clinic.

8. I understand that occasionally, due to emergencies, I may not be seen at my appointment time or may be seen by a different doctor. I also understand that if I am late to my appointment, it is possible that I may not be seen that day.

9. I understand that the clinic operates on any appointment schedule and that if I walk in without a scheduled appointment, I will not be able to be seen unless there is a cancellation.

10. I understand that if I have lab testing done, I will be notified of the results at my next appointment. Should results be abnormal and require a change in therapy, I will be notified by the nurse.

11. I understand that if I am referred to the hospital or any other facility for additional testing, I will be responsible for the charges associated with this visit. I also understand that I am able to apply for the indigent program at Northeast Georgia Medical Center, Union General Hospital or the hospital/radiology center closest to my home.

12. I understand that, for safety reasons, children without appointments are not allowed in the exam rooms: please make baby-sitting arrangements prior to appointment.

13. I understand that I must see the doctors in this clinic and that if I am seeing another doctor (unless referred by our clinic) I am not qualified to receive care here. If I start going to another doctor, I will promise to stop coming to Healing Hands Community Clinic. If Healing Hands Community Clinic discovers I am being seen by another physician, I will automatically be discharged as a patient.

Patient Signature

Date

NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPAA provides penalties for covered entities that misuse personal health information.

As required by HIPPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information. We may use and disclose your medical records only for each of the following purposes:

- Treatment-means providing, coordinating or managing your health care and related services by one or more health care providers. An example of this would include a physical examination. It could mean evaluating your problem, like possible urine infection. It could also mean talking to another doctor who cares for you to discuss your problems or care.
- Health Care Options-include the business aspects of running Healing Hands Community Clinic, such as conducting quality assessment and improvement activities such as auditing functions.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information as required by government agencies. We will disclose information as required by law to the proper agency such as outlined by the laws regarding child abuse, spousal abuse, or commission of a felony. We will report required information on infectious diseases as required by law.
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the office:

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- Unless you specifically tell us differently, we will discuss your care with your family: for example, discussing your progress with family if you are hospitalized, or leaving a message about need for medication change or lab results, giving information about your medications, appointments or care.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice upon request