**PATIENT INFORMATION FORM PATIENT ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FULL NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE**: \_\_\_\_\_\_\_\_\_ LAST MI FIRST

**WHAT SERVICES ARE YOU NEEDING HELP WITH**:

**Medical [ ] Pharmacy [ ] Mental Health [ ] Dental [ ] Vision [ ] Spiritual [ ] Other [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have Health Insurance?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Have you applied for health insurance?** \_\_\_\_\_\_\_\_\_\_\_\_ \**To be eligible for services all patients must provide proof of application -OR- meet with our insurance counselors.*

**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE:** \_\_\_\_\_\_ **SEX**: \_\_\_\_\_\_\_**SOCIAL SECURITY** **NO.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOTAL NUMBER IN HOUSEHOLD:** \_\_\_\_\_\_\_\_\_ **CHILDREN: \_\_\_\_\_\_ TOTAL MONTHLY INCOME:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(FEMALE PATIENTS ONLY):* ARE YOU PREGNANT \_\_\_\_\_\_

LMP: \_\_\_\_\_\_\_\_\_\_ NURSING: \_\_\_\_\_\_\_\_\_\_\_ TAKING ORAL CONTRACEPTIVES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS: (*All prescription & non-prescription medications.)***

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **CAPSULE/TABLET** | **STRENGTH** | **HOW OFTEN TAKEN** |
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**\*Do you use controlled substances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT HISTORY: (**Check)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| AIDS/HIV | BLOOD TRANSFUSION | CONVULSIONS | EXCESSIVE THIRST | HEART ATTACK/ FAILURE | HIGH BP | LOW BLOOD PRESSURE | RENAL DIALYSIS | STOMACH DZ | STD’S |
| ALZHEIMERS | BREATHING PROBLEMS | CORTISONE MEDICINE | FAINTING SPELLS/ DIZZINESS | HEART MURMUR | HIGH CHOLES-TEROL | MITRAL VALVE PROLAPSE | RHEUMATIC FEVER | STROKE | JAUNDICE |
| ANAPHYLAXIS | BRUISE EASILY | DIABETES | FREQUENT COUGH | PACEMAKER | HIVES OR  RASH | OSTEOPOROSIS | RHEUMATISM | LIMB SWELLING | OTHER: |
| ANEMIA | CANCER | DRUG ADDICTION | FREQUENT DIARRHEA | HEART TROUBLE/DZ | HIGH BLOOD SUGAR | PAIN IN JAW JOINTS | SCARLET FEVER | THYROID DZ |  |
| ANGINA | CHEMO | EASILY WINDED | FREQUENT HEADACHE | HEMOPHILLA | IRREGULAR HEARTBEAT | PARATHYROI DZ | SHINGLES | TONSILLITIS |  |
| ARHTRITIS | CHEST PAIN | EMPHYSEMA | GENITAL HERPES | HEP A | KIDNEY PROBLEMS | PSYCHIATRIC CARE | SICKLE CELL DZ | TB |  |
| ARTIFICIAL HEART VALVE | COLD SORES | EPILEPSY / SEIZURES | GLAUCOME | HEP B OR C | LEUKEMIA | RADIATION TX | SINUS TROUBLE | TUMORS |  |
| BLOOD DZ | CONGENITAL HEART D/O | EXCESSIVE BLEEDING | HAY FEVER | HERPES | LIVER DZ | RECENT WT LOSS | SPIINA BIFIDA | ULERS |  |

**Surgical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPAA- PATIENT ACKNOWLEDGMENT FORM**

**FULL NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION**

OUR NOTICE OF PRIVACY PRACTICES (NPP) PROVIDES INFORMATION ABOUT HOW LONG MTN. HOME CHRISTIAN CLINIC, MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU. THE PRACTICE PROVIDES THIS FORM TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). THE NPP CONTAINS A PATIENTS RIGHTS SECTION DESCRIBING YOUR RIGHTS UNDER THE LAW. PLEASE REVIEW THE NOTICE OF PRIVACY PRACTICES THOROUGHLY BEFORE SIGNING THIS FORM, YOU ACKNOWLEDGE THT OUOR PRACTICE MAY USE AND DISCLOSE PHI ABOUT YOU FOR TREATMENT, PAYMENT, AND HEALTHCARE OPEREATIONS. YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT HOW PHI ABOUT YOU IS USED OR DISCLOSED FOR TREATMENT, PAYEMNT, OR HEALTHCARE OPERATIONS.

I GIVE PERMISSION FOR MHCC TO**: LEAVE A MESSAGE REGARDING AN** \_\_\_\_**APPOINTMENT** \_\_\_\_**TEST RESULTS**\_\_\_\_**DETAILED MESSAGE**

AT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (HOME, CELL, WORK PHONE)- CIRCLE ONE

I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING DIAGNOSIS, RECORDS, EXAMINATION RENDERED TO ME MAY BE RELEASED TO:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_(PHONE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OR \_\_\_\_ **INFO NOT TO BE RELEASED TO ANYONE**

***THE RELEASE INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING***

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MHCC CONSENT TO TREATMENT/CARE**

* I UNDERSTAND THAT TO BE ELIBIBLE FOR SERVICES FROM MHCC, I MUST HAVE A NEED THAT IS NOT BEING ADEQUATELY ME BY OTHER RESOURCES IN THE COMMUNITY.
* I AGREE TO REPORT ANY CHANGES IN MY HEALTH INSURANCE STATUS TO MHCC. TO PROVIDE PROOF THAT I HAVE APPLIED FOR INSURANCE OR TO MEET WITH MHCC INSURANCE COUNSELORS.
* WHEN I BECOME ENROLLED IN AN INSURANCE PROGRAM, I UNDERSTAND IT IS MY RESPONSIBILITY TO CHOOSE A PRIMARY CARE PROVIDER AND TO ENROLL AS A NEW PATIENT. MHCC HAS A LIST OF AVAILABLE PROVIDERS IN THE AREA.
* I UNDERSTAND THT THE HEALTH CARE PROFESSIONALS ARE LICENSED BY THE STATE OF ARKANSAS IN THEIR RESPECTIVE FIELDS AND ARE VOLUNTEERING THEIR TIME AND SERVICES AND/OR ARE NOT CHARGING ME A FEE FOR MY CARE DIRECTLY. THIS IMPILES- A) Being seen by a professional at MHCC does not entitle me to follow up care at the provider’s private office or obligate him/her to provide me with continuing care or treatment. B) These healthcare providers are immune from civil suits regarding their services to me as a clinic patient.
* I UNDERSTAND THT MHCC MAY REFER ME TO OTHER AGENCIES OR MEDICAL PROVIDERS FOR SERVICES THAT ARE NOT AVAILABLE TRHOUGH THE CLINICL. I UNDERSTAND THAT MHCC DOES NOT PAY FOR SERVICES PROVIDED OUTSIDE THE CLINIC, AND I WILL BE RESPONSIBLE FOR SUCH COST. IT IS MY RESPONSIBILITY TO APPLY FOR WHATEVER FINANACIAL ASSISTANCE MAY BE AVAILABLE.
* I UNDERSTAND THAT MHCC IS A SMOKE FREE CLINIC BOTH IN THE BUILDING AND ON THE GROUNDS.
* I UNDERSTAND THE MHCC HAS A STRICT NO WEAPONS POLICY.
* I GIVE PERMISSION AND CONSENT FOR EACH OF THE FOLLOWING: A) If I am referred to another healthcare provider, my records may be copied and shared with the provider; B) to obtain medical records, test results, or x-rays from other healthcare facilities or providers to aid in my diagnosis and treatment; C) for MHCC staff to perform test or procedures needed to aid in the diagnosis and treatment of my illness; D) for samples of my blood to be tested at no cost to me for evidence of infection should a healthcare provider be exposed to blood/body fluid in a way that might allow transmission of infection due to blood-borne disease (i.e. HIV/ Hepatitis) or other communicable disease, for the safety, health, and possible treatment of the healthcare provider; E) for my photograph to be taken during clinic activities; I do not object to the use of my photograph for MHCC purposes, such as the newsletter or on social media.
* MHCC PARTICIPATES IN AR DONATED MEDICATIONS PILOT PROGRAM, WHICH ALLOWS US TO ACCEPT UNEXPIRED MEDICATIONS FROM NURSING HOMES TO RE-DISPENSE THROUGH OUR PHARMACY. CHECK BELOW TO INDICATE WHETHER OR NOT YOU CONSENT TO RECEIVE THESE MEDICATIONS. IF YOU DO NOT CONSENT, PLEASE LIST AN ALTERNATE PHARMACY WHERE WE MAY CALL IN YOUR PRESCRIPTIONS TO IF WE DO NOT HAVE THE DRUG IN STOCK. THIS WILL BE AT A COST TO YOU.

**[ ] I CONSENT [ ] I DO NOT CONSENT (ALTERNATE PHARMACY & PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**

I HAVE READ AND I UNDERSTAND THE PRECEDING STATEMENT IN THIS CONSENT FORM. I CERTIFY THAT THE INFORMATION AND DOCUMENTS I HAVE PROVIDED ARE TRUE, ACCURATE, AND COMPLETE. I AGREE TO INFORM MHCC AS SOON AS POSSIBLE OF ANY CHANGES, INCLUDIG ADDRESS, PHONE, AND INSURANCE INFORMATION.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT NAME (PRINTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS BY (MHCC STAFF): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEAVE BLANK FOR OFFICE PURPOSES: