Compassionate Care of Shelby County
Client Intake Worksheet

Date of call: ________ Signature of who took call: ______________ Revised 07-20-10

Name: ____ **DOB:** __________ **age**____
Last First MI

Ethnicity: African American __ Asian __ Hispanic __ Middle Eastern __ Native American __
White __ Other ___________ Sex: Male ___ Female ___

Address: ____ **Phone:** ____________
Street City Zip

SS#: ____________________ **School District** ______________________________

Marital Status: Single Married Divorced Legally Separated Widowed

Employment Status: Full time Part time Unemployed Disabled Student Child
(If employed) Employer: _______________ Wage/Salary: ____________________
Laid off? y/n From where?_____________ Are you expected to return to work? y/n When______
Do you receive Unemployment: yes no Amount:______________

Number in household _______ **#children** _______
Do you or anyone in your household receive any of the following income(s)?

SSI:	yes	no	Amount:______________
Disability:	yes	no	Amount:______________
Workman's comp.:	yes	no	Amount:______________
Retirement:	yes	no	Amount:______________
Child support:	yes	no	Amount:______________

Did you file taxes last year? yes no
If yes, please bring in your 1040 form and any above income verification(s).

Any Other sources of income: ________________________ Total Household Income __________

People currently living in home:

Name	Age	Relationship	Income/Benefits

Insurance status: Uninsured: ___ Insurance: __________ DOES PT. HAVE MEDICAL CARD? __
Does Patient have: Medicare yes or no Medicaid yes or no Veteran Benefits yes or no

Education Level: Some High School ___ Graduated HS ___ GED ____ Some College ___
Bachelors ___ Post Bachelors ___

Primary Language ______________

Appointment Date:________________________ Appointment Time:__________________

Reason for Appointment____
If new patient needs medicine, what would the medication be for?___________________________

Compassionate Care

Health History

Patient Name:______________________ Date of Birth: __________ Male Female

What illnesses do you have?

Please check the illnesses you have had in the past and list the date	
☐Heart Disease	☐Circulatory Problems
☐High Blood Pressure	☐Physical Disability
☐Stroke	☐Chronic Pain
☐Lung Disease or Breathing Problems	☐Skin Condition
☐Cancer	☐Mental Health Problems
☐Kidney/Urinary Problems	☐Thyroid Disorder
☐GI/Liver Problems	☐Seizure Disorder
☐Diabetes	☐Other
☐Other	☐Other

When was the last time you saw a doctor? ______________________

What doctor did you see? ______________________

Tell us what drugs you **CAN NOT** take?

Known, list reaction, date (Ex.: PCN – Hives, 1980's Motrin – Heartburn, 10/06)

1	
2	
3	
4	
5	
6	

Please turn this page over and complete the other side

Compassionate Care

Tell us what drugs you are ***supposed*** to be taking

	Medication name & Dose	# and Frequency	Who ordered?	When was it ordered?	Are you taking this medicine now?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Use of Tobacco Products: ☐Never ☐Rarely ☐Moderately ☐Heavy ☐Quit

_______ packs per day (Quit Date) ____/____/____

Use of Alcohol Products ☐Never ☐Rarely ☐Moderate ☐Daily

Type of Product: ______________________________

Use of Illegal Drugs: ☐Never ☐Rarely ☐Moderately ☐Daily ☐Quit

Type of Drugs: ________________ (Quit Date) ____/____/____

Exercise:
Type of exercise: ______________________________

Times per week: ______________________________

Please turn this page over and complete the other side

Compassionate Care of Shelby County

WELCOME TO COMPASSIONATE CARE!

As a patient of Compassionate Care, you are very important to us. It is our honor to provide you with healthcare services. It is the policy of Compassionate Care to let you know your rights and responsibilities as our patient. These rights and responsibilities are based on the following Core Values:

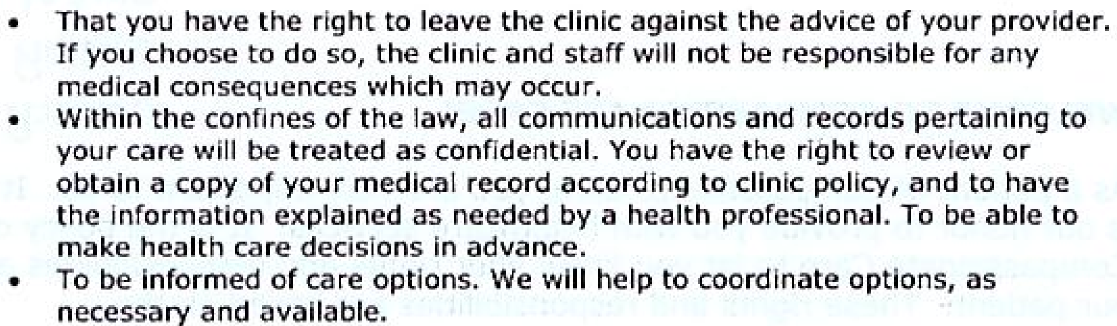
- We believe that all patients deserve to be treated with dignity and respect, regardless of race, religion, or ability to pay.
- We believe that part of our mission is to promote health and wellness.
- We believe in maintaining high standards of operation for the clinic, and professionalism for our staff and volunteers.
- We believe in good stewardship of all resources and services.

In order to serve you best, it is necessary for us to work as a team. The following will outline the responsibilities of members of this team:

OUR RESPONSIBILITIES

As a patient at Compassionate Care you can expect:

- Considerate, respectful, and compassionate care regardless of your age, race, gender, religion, national origin, sexual orientation, or physical or mental disability.
  - Attention when you request help, with the understanding that other patients may have more urgent needs.
  - To be addressed by your proper name.
  - Care provided in a safe setting.
  - Care provided by concerned staff.
  - Coordination of sign language or foreign language interpretation services, if you need them.
- To be told the names of the volunteer doctors, nurses, and other health team members directly involved in your care.
- Information about your diagnosis, treatment, and expected result to be provided by your volunteer provider.
  - Information on the planned course of treatment, including an explanation about procedures.
  - Information on the risks, benefits, and alternatives of your treatment.
  - Freedom from the use of seclusion or restraints in any form unless clinically required.
- To make decisions about your plan of care before and during treatment, when medically possible.
- To refuse a recommended treatment to the extent permitted by law, and to be informed of the medical consequences of your refusal.



- That you have the right to leave the clinic against the advice of your provider. If you choose to do so, the clinic and staff will not be responsible for any medical consequences which may occur.
- Within the confines of the law, all communications and records pertaining to your care will be treated as confidential. You have the right to review or obtain a copy of your medical record according to clinic policy, and to have the information explained as needed by a health professional. To be able to make health care decisions in advance.
- To be informed of care options. We will help to coordinate options, as necessary and available.

YOUR RESPONSIBILITIES –

As a patient, you and /or your representative are expected to:

- Provide complete and accurate information about your health, including present condition, past illnesses, hospitalizations, medications, natural products and vitamins, and any other matters that pertain to your health.
- Provide complete and accurate information including your full name, address, home telephone number, date of birth, Social Security number, and employer when it is necessary.
- Comply with medical treatment plan as prescribed by your volunteer provider.
- Ask questions when you do not understand what your doctor or other member of your health care team tell you about your diagnosis or treatment. You should inform your doctor if you anticipate problems in following prescribed treatment. Inform your doctor if you are considering alternative therapies.
- Keep appointments, be on time for your appointments, and call as soon as possible if you cannot keep your appointments.
- Abide by all hospital rules and regulations.
  - Comply with the NO SMOKING policy.
  - Refrain from the use of illegal drugs and/or alcohol while at the clinic.
  - Treat clinic staff, other patients, and visitors with courtesy and respect.
  - Refrain from foul language or other aggressive behaviors while at the clinic.

Thank you for allowing us to assist with your health and wellness. Please sign below as acknowledgement of your receipt of this document.

Name: ______________________________________(Please Print)

Signature: ______________________________

August 2007

Compassionate Care Free Clinic
P.O. Box 4835
Sidney, Ohio 45365

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Because Compassionate Care neither bills nor communicates with health insurance companies electronically, we are a 'non-covered entity' under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, it is our policy to maintain the privacy of your health information even though we are not subject to HIPAA requirements. This notice explains our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices described in this notice while it is in effect, beginning August 1, 2007 and until we replace it. If we change this notice and our privacy practices we may make the changes effective for all health information that we maintain, including health information we created or received before we made the changes. You may request a copy of this or future versions of this notice by contacting the Compassionate Care executive director.

ACKNOWLEDGEMENT OF RECEIPT

We will ask you to sign an acknowledgment that you received this notice. However, your care will not depend on signing the acknowledgement and we will continue to provide your treatment and will use and disclose your health information as necessary within the provisions of this notice.

YOUR RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions such as certain mental health information. Requests must be in writing and signed by you. You may request a form for this purpose from the office.

Release of Health Information: You may request that we provide copies of your health care information to others. To do so, submit a signed, written request authorizing us to do so. Forms are available. You may revoke your authorization in writing at any time.

Correction: You may ask Compassionate Care to correct health information we have created if the information is wrong or incomplete. Correction requests must be submitted in writing with an explanation of why you want the information changed. Your request may be denied if the information is correct or was not created by Compassionate Care.

Accounting of Disclosures: You have the right to know with whom Compassionate Care has shared your health information, other than within Compassionate Care. Requests must be submitted in writing and include your signature.

Request Restrictions: You may ask us not share your health information with certain individuals for certain purposes, including family members who may be involved n your care. To ask for restriction, send your request in writing to Compassionate Care and clearly state with whom you want us to restrict your information and to what extent. Please note that we are not required to comply with your request if we believe it necessary to share your information.

Confidential Communications: You may specify where and how our staff may contact you, such as only at work or by mail. Submit your request in writing, stating how or where you wish to be contacted.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and may disclose to others health information about you for the following purposes:

Treatment: We may use or disclose your health information to a physician or other healthcare professional who is providing treatment to you (e.g., laboratories, specialists, hospitals).

Appointment Reminders: We will use information about you to remind you of an upcoming appointment via telephone or mail.

Translators: We may share your medical information with translators to assist in scheduling appointments and treating you.

Family and/or Friends: We may share information about you with a family member or friend who you have said is involved in and/or responsible for your care. You have the right to stop or limit the disclosure of information in this way.

Treatment Alternatives and Health Related Benefits and Services: We may disclose your information to explore and recommend possible treatment options, benefits and services that may exist for you.

Fundraising and Publicity: We may use medical information about you to contact you about opportunities for you to assist in efforts to increase awareness of or to raise money to support Compassionate Care.

As Required by Law: We will share your health information when the law requires us to do so. Applicable circumstances include but are not limited to reporting public health threats such as infectious diseases, reporting suspected abuse, violence or neglect victims, complying with subpoena, summons, and other lawful procedures, and providing information needed for a correctional or other custodial residential entity to provide health care to you or to protect the health and safety of others

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have not been maintained while receiving our services, you may file a complaint with Compassionate Care at the address shown on page 1 or with the U.S. Department of Health and Human Services. All complaints must be in writing. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT:

My signature below acknowledges that this 2 page notice has been given to me to review and that I have been offered and received a copy if I so desire.

Signature ____ Date ________________

Name Printed ____

Compassionate Care of Shelby County
Voluntary Care
Consent for Treatment

Name: ____ **DOB:** ____________
Last First MI

Address: __________________________ **Phone:** __________
City Zip

SS#: ______________

I hereby consent to the provision of diagnosis, care, and/or treatment by Compassionate Care of Shelby County, Inc. and acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

I understand that by signing this voluntary care patient consent form, I cannot bring a tort or other similar action, including an action on a medical or other health-related claim, against Compassionate Care of Shelby County unless the action or omission of Compassionate Care of Shelby County constitutes willful or wanton misconduct.

If a Compassionate Care of Shelby County volunteer physician, physician assistant, nurse practitioner or clinical nurse specialist has determined that some form of further treatment is needed, I understand that the follow-up care, consultation or other treatment may not be available through Compassionate Care of Shelby County. Therefore, all services rendered are determined by the level of funding available at any given time. I also understand that Compassionate Care of Shelby County is designed to assist patients to the best of their ability, but must function within its scope of practice and funding limitations.

____

*Signature of Patient or Person Authorized to Consent** *Date*

____

Relationship (if not patient)

____

Witness (Compassionate Care representative)

**If this consent for treatment is signed by someone other than the patient, it must be signed in the presence of the patient and the Compassionate Care representative.*

FTCAPatient Notice of Limited Liability of
FTCA Deemed Volunteer Free Clinic Health Care Professionals

NOTICE TO PATIENTS

This document is 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 practicable:

Or

To a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

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 health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).
Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal law.

Acknowledged: ______________________________ (Patient Signature)

______________________________ (Patient Name, **printed** legibly)

Date Signed: ____________________

Copy to Medical Record
Copy to Patient

Compassionate Care of Shelby County

124 N. Ohio *Sidney, Ohio 45365* *937-492-9400*
Fax: 937-492-9407

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person do hereby authorize the release of my medical information, as indicated herein, between the following parties:

To/From: CCSC
124 N. Ohio
Phone: 937-492-9400

From/To: ____________________
____
____
____

I authorize this release of information to either ☐ verify services rendered to process a claim for benefits, ☐ to provide continuity to my medical care, ☐ at the request of the individual, ☐ other____________________________.

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by Federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for sixty (60) days from the date of my signature below unless I specify an earlier expiration date in this space____________________. I understand, also, that except to the extent that has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved. (see Notice of Privacy Practices).

It is my desire that only the information in my ☐clinic record, ☐ambulatory testing (please check the appropriate boxes) indicated below is to be released as a result of this authorization:

☐ Face Sheet	☐ Laboratory Reports	☐ Therapy Reports
☐ History & Physical	☐ Operative Reports	☐ Emergency Treatment
☐ Discharge Summary	☐ Pathology Reports	☐ Other specified here:___
☐ Consultation Reports	☐ Physician Progress Notes	____________________
☐ Radiology Reports	☐ Physician Orders	____________________

I am also making the following additional qualification: IF the information specified above contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, or HIV test results or diagnosis, I am including this type of information to be released in association with this authorization.

__________ ____________________________ ____________________
(Date) (Patient or Guardian Signature) (Witness)

Patient Name:______________________________ Birthdate:______________
Address:____
Telephone Number:____________________

Form **4506-T**

(Rev. January 2010)

Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

► **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can also call 1-800-829-1040 to order a transcript. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return**. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.

1b First social security number on tax return or employer identification number (see instructions)

2a If a joint return, enter spouse's name shown on tax return.

2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Caution. *If the transcript is being mailed to a third party, ensure that you have filled in line 6 and line 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ► ____________

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days. ☐

c **Record of Account,** which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you did **not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2007, filed in 2008, will not be available from the IRS until 2009. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days ☐

Caution. *If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.*

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

____________ ____________ ____________ ____________

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of signature date.*

Telephone number of taxpayer on line 1a or 2a

Sign Here

► Signature (see instructions) | Date

► Title (if line 1a above is a corporation, partnership, estate, or trust)

► Spouse's signature | Date

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 37667N