HEART SOUL FREE CLINIC

Where Healing Meets Hope

Patient Demographic Form

Thank you so much for visiting the Heart and Soul Free Clinic! Your answers to the following questions aids us in securing the grant funding that allows us to provide free medical and dental care. All of your answers will be kept strictly anonymous, so please answer as accurately as possible. For the purpose of this form, the term household is defined as all the persons who occupy a housing unit as their usual place of residence. A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied (or if vacant, is intended for occupancy) as separate living quarters.

Today's Date _____ / _____ / _____

Patient Name: _____ Age of **Patient**: _____ years old **Patient's** Zip code: _____

Patient's Gender: FEMALE MALE OTHER:_____

1) In the last year, has the **patient** struggled to secure immediate and or affordable mental health care? YES NO

2) Is there an individual in the **patient's** household who is disabled or handicapped? YES NO

Is the **patient** being seen disabled? YES NO

3) Does the **patient** work: FULL-TIME PART-TIME UNEMPLOYED DOES NOT APPLY

4) Does a lack of transportation hinder the **patient** from: OBTAINING FOOD RECEIVING MEDICAL CARE WORKING

5) **Patient's** current housing situation: RENT OWN DOES NOT HAVE HOUSING OTHER:_____

6) In the last 6 months, has the **patient** been unable to pay for or obtain food? YES NO

7) In the last 6 months, has the **patient** been unable to pay their utilities? YES NO DOES NOT APPLY

8) Has the **patient** being seen received assistance from their township trustee in the last 12 months? YES NO

9) Has the **patient** been released from incarceration in the last 90 days? YES NO

10) Does the **patient** smoke? YES NO

If yes, would the **patient** like to receive information about the Indiana Smoking Cessation Program? YES NO

11) In the last 6 months, has the **patient** experienced any concerns with drugs or alcohol? YES NO

12) What is the **patient's** primary language (i.e. English, Spanish, Arabic, Mandarin)? _____

13) Does the **patient** require an interpreter? YES NO

14) Does the **patient** being seen have medical insurance? YES NO

If yes, what type? (i.e Medicare, Medicaid, Employer): _____

15) Does the **patient** being seen have a Primary Care Physician? YES NO

16) Does the **patient** being seen have dental insurance? YES NO

If yes, what type? (i.e Medicare, Medicaid, Employer): _____

Please Turn Page to the Other Side

17) **On the Table Below:**

1) Please circle the number of individuals in the **patient's** household.
2) Please circle the **patient's** total annual household income corresponding with the number of individuals in the **patient's** household.

1	0 - $16,250	$16,251 - $27,050	$27,051 – $43,250	More than $43,250
2	0 - $18,550	$18,551 - $30,900	$30,901 - $49,400	More than $49,400
3	0 - $20,850	$20,851 - $34,750	$34,751 - $55,600	More than $55,600
4	0 - $25,100	$25,101 - $38,600	$38,601 - $61,750	More than $61,750
5	0 - $29,420	$29,421 - $41,700	$41,701 - $66,700	More than $66,700
6	0 - $33,740	$33,741 - $44,800	$44,801 - $71,650	More than $71,650
7	0 - $38,060	$38,061 - $47,900	$47,901 - $76,600	More than $76,600
8	0 - $42,380	$42,381 - $51,000	$51,001 - $81,550	More than $81,550

18) Number of persons in **patient's** household: ADULT(S) _____ CHILDREN _____

19) How does the **patient** identify? (Circle All That Apply)

American Indian or Alaska Native
Asian
Black or African American
Arabic
Native Hawaiian or Other Pacific Islander
White
Hispanic
Other: _____

20) **Patient's** marital status: MARRIED SINGLE WIDOW/WIDOWER

21) Does the **patient** reside in a single parent household? YES NO

If yes, Is the single parent FEMALE MALE OTHER

22) **Patient's** Level of Education (Please Circle One)

Current Student (Under 18 years old)
School Attending:_____
Current Student (Over 18 years old)
School Attending:_____
Some School (No Diploma)
High School Graduate/GED
Some College
College Graduate

23) Does the **patient** being seen receive any of the following? (Circle All That Apply)

Food Stamps
WIC
Public Housing/Section 8
Medical Assistance
Temporary Assistance to Needy Families (TANF)
Supplemental Security Income (SSI)
Children's Health Insurance Program (CHIP)
Qualified Medicare Beneficiary

24) How did the **patient** hear about Heart and Soul? (i.e. Friend, Family, Grace Care Center, Trinity Free Clinic, Hope Clinic)?

_____

HEART SOUL FREE CLINIC
Where Healing Meets Hope

HEART AND SOUL REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Cell phone#: ( )	Home phone #: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

You may **release** medical information to the following:

Name	Relationship	Phone

The above information is true to the best of my knowledge.

Patient Signature **(parent signature if patient is under 18 years old)** Date

4/7/2016

Heart and Soul Clinic

17338 Westfield Park Road • Westfield, IN 46074 (317)804-5782

Medical & Dental History Form

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Do you have any allergies? ◯ Yes ◯ No

If 'yes' to allergies, please list.

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Name and relationship to patient:

Response Date: ____/____/_____

Appendix C
FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

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

Notice to Patients

To be 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 its 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 an 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)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997, may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

Acknowledged:

_____
(Patient Signature)

_____
(Patient name, printed legibly)

_____
Date

Proposed Project: Free Clinic FTCA Deeming Application (OMB No. 0915-0293) Revision

HEART AND SOUL CLINIC, INC.
P.O. Box 478
Westfield, IN 46074

RELEASE OF INFORMATION

(English)

For and in consideration of the medical treatment and/or consultation made available to me without charge at Heart and Soul Clinic, Inc., I hereby agree to the following terms:

I hereby grant Heart and Soul Clinic, Inc. full and unrestricted access to all of my health records, regardless of their location and/or of whose custody the health records are currently in.

I hereby release, relieve and discharge from liability Heart and Soul Clinic, Inc., its officers, directors, agents employees, and volunteers of and from all liability for any and all losses, injuries, or damages to either my person or to my property, occasioned by, in any manner growing out of, or as a direct or indirect result of my receipt of any diagnosis, consultation, procedures, medications, treatments or advise or by anyone providing any such diagnosis, consultation, procedures, medications, treatment or advise in which the Heart and Soul Clinic, Inc. has any responsibility or its made available by it.

I hereby give my permission to the Heart and Soul Clinic, Inc. its agents and volunteers to treat me during this clinic visit and all subsequent visits and to provide drugs, medical care and other services and supplies as are needed for my health and well-being. I acknowledge that no representations, warranties or guarantees as to results or cures have been made to me by Heart and Soul Clinic, Inc., or its agents, nor have I relied upon any such representations, warranties or guarantees.

I hereby give my permission for the Heart and Soul Clinic, Inc., to pursue other health professionals in consultation/referral regarding my medical condition for the purpose of continuity of health care. I am aware that the Heart and Soul Clinic, Inc., cannot guarantee the care provided by a referring physician or health care specialist will be rendered free of charge to me and that the Heart and Soul Clinic, Inc., cannot assume responsibility for payment.

By my signature below, I certify that I have read this ***Release of Information*** (or have had the same read to me) and that I fully understand its provisions I now voluntarily sign the ***Release*** as evidence of my intent and agreement to be bound by it.

----------***(Spanish ~ Espanol)***----------

En consideracion a la consulta y al tratamiento medico que gratuitamente he reeibido por parate de la clinica, Heart and Soul Clinic, Inc., por este conducto doy me consentimiento a los siguientes terminus:

Doy mi consentimiento para que Heart and Soul Clinic, Inc., tenga acceso sin restriccion alhuna a mis expedients medicos, sin importer el lugar y/o la custodia donde se encuentren actualmente.

Libero de toda responsabilidad o cargo de demanda a la clinica, Heart and Soul Clinic, Inc., a sus oficiales, directores, agents, resultado de, o directa o indirectamente como resultado del diagnostico, consulta, procedimientos, medicamentos, tratamientos o consejo en los cuales la clinica, Heart and Soul Clinic, Inc., tenga responsabilidad alguna o este involucrate en la disponibilidad de dichos servicios.

Por medio de este documento, doy mi consentimiento a la clinica, Heart and Soul Clinic, Inc., sus agenies y voluntarios para que me dentratamiento durante mi visita a la clinica y todas las visitas subsequentes, asi comom para recetarme medicamentos, darme cuidados medicos y otros servicios y materiales, segun sea necesario para mi salud y mi bienestar. Reconozco que, ni Heart and Soul Clinic, Inc., ni sus volungarios me han ofrecido nongun tipo de esa garantias.

Por medio de este documento, doy mi consentimiento a la clinica, Heart and Soul Clinic, Inc., para consultar con ostros medicos profesionales respecto a mi condicion medica con el proposito de continuar con mis cuidandos de salud. Estoy consciente de que la clinica Heart and Soul Clinic, Inc., no so hara responsible por pagos que se puedan adeudar a dichos especialista.

Por medio de mi firms en este documento, certifleo que he tenido la oportunidad de leer este consentimiento (o que el mismo me has sideo leido por una tercera persona) y ratifico que comprndo en su totalidad su contenido. A continuacion firmu voluntariamente este consentimiento como evidencia de me acuerdo a lo aqua antes estipulado.

_____ _____

Printed Name/Nombre del paciente impreso Date/Feche

_____

Patient Signature/Firma del paciente

_____ _____

Patient Representative/Reprosentante del pacient Relationship/Relacion con el pacente

HS006 4/7/2016