flint hills community clinic

"Our community, Our Clinic"

PATIENT PROFILE

DATE: INTAKE ASSISTANT:

First: Middle: Last:

DOB: SSN: Photo ID:

Street 1: Street 2:

City: State: Zip Code:

County: Country:

Home Phone: Work Phone: Ext:

Pager: Mobile Phone:

Email:

Emergency Contact: Phone Number:

Sex
- ☐ Male
- ☐ Female

Race
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian/ Pacific Island
- ☐ Multi-Racial
- ☐ Pakistan
- ☐ Other
- ☐ Unknown

Ethnicity
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Middle Eastern
- ☐ Native American
- ☐ Other
- ☐ White

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow

Covered by Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ Tri-Care
- ☐ VA Benefits
- ☐ Other Insurance

Other Info
- ☐ Language: _____
- ☐ Education Level: _____

Number of Children: Number in Family:

☐ Veteran ☐ US Citizen ☐ US Resident ☐ Head of Household

MOST RECENT ELIGIBILITY DATE:

PATIENT ALLERGIES

flint hills community clinic

"Our community, Our Clinic"

☐ **NO KNOWN ALLERGIES**

ALLERGY:	
RESPONSE:	
DATE OF ONSET:	

ALLERGY:	
RESPONSE:	
DATE OF ONSET:	

ALLERGY:	
RESPONSE:	
DATE OF ONSET:	

ALLERGY:	
RESPONSE:	
DATE OF ONSET:	

ALLERGY:	
RESPONSE:	
DATE OF ONSET:	

flint hills community clinic

"Our community, Our Clinic"

PATIENT FAMILY HISTORY

Please check all that apply to your family

- ☐ Allergies
- ☐ Anemia anticoagulation
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding
- ☐ Blood Plasma
- ☐ Bowel Disease
- ☐ Cancer
  - Type: _____
- ☐ COPD
- ☐ Depression
- ☐ Dental Disease
- ☐ Diabetes
  - ☐ Type I
  - ☐ Type II
- ☐ Diarrhea
- ☐ Eye Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ Gout
- ☐ Heart Disease
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Back Pain
- ☐ Major Blood Vessel Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Multiple Sclerosis or Nerve Disease
- ☐ Musculoskeletal Disorder
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Obesity
- ☐ Peripheral Arterial Disease
- ☐ Prostate
- ☐ Thyroid
- ☐ Transfusions
- ☐ Skin disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Venereal Disease
  - Type: _____

INFECTIOUS DESEASES

- ☐ AIDS of HIV
- ☐ Cholera
- ☐ Chicken Pox
- ☐ Dengue
- ☐ Ebola
- ☐ Encephalitis
- ☐ Guinea Worm
- ☐ Hepatitis
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ Parasite Infection
- ☐ Poliomyelitis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tetanus
- ☐ Trachoma
- ☐ Tuberculosis
- ☐ Whooping Cough

flint hills community clinic

"Our community, Our Clinic"

PATIENT HOUSEHOLD MEMBERS

1. Patient Name: _____ D.O.B: _____

Sex
- ☐ Male
- ☐ Female

Race
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian/Pacific Island
- ☐ Multi-Racial
- ☐ Pakistan
- ☐ Other
- ☐ Unknown

Employment
- ☐ Disabled
- ☐ Employed - FT
- ☐ Employed – PT
- ☐ Minor
- ☐ Retired
- ☐ Student
- ☐ Unemployed

Monthly Income

Salary/Wages	
Child Support	
Unemployment	
SSI	
Social Sec. Disability	
Other	
Total Income	

2. Name: _____ D.O.B: _____

Relation: _____

Sex
- ☐ Male
- ☐ Female

Race
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian/Pacific Island
- ☐ Multi-Racial
- ☐ Pakistan
- ☐ Other
- ☐ Unknown

Employment
- ☐ Disabled
- ☐ Employed - FT
- ☐ Employed – PT
- ☐ Minor
- ☐ Retired
- ☐ Student
- ☐ Unemployed

Monthly Income

Salary/Wages	
Child Support	
Unemployment	
SSI	
Social Sec. Disability	
Other	
Total Income	

flint hills community clinic

"Our community, Our Clinic"

PATIENT HOUSEHOLD MEMBERS

3. Name: _____ D.O.B: _____

Relation: _____

Sex
- ☐ Male
- ☐ Female

Race
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian/Pacific Island
- ☐ Multi-Racial
- ☐ Pakistan
- ☐ Other
- ☐ Unknown

Employment
- ☐ Disabled
- ☐ Employed - FT
- ☐ Employed – PT
- ☐ Minor
- ☐ Retired
- ☐ Student
- ☐ Unemployed

Monthly Income

Salary/Wages	
Child Support	
Unemployment	
SSI	
Social Sec. Disability	
Other	
Total Income	

4. Name: _____ D.O.B: _____

Relation: _____

Sex
- ☐ Male
- ☐ Female

Race
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian/Pacific Island
- ☐ Multi-Racial
- ☐ Pakistan
- ☐ Other
- ☐ Unknown

Employment
- ☐ Disabled
- ☐ Employed - FT
- ☐ Employed – PT
- ☐ Minor
- ☐ Retired
- ☐ Student
- ☐ Unemployed

Monthly Income

Salary/Wages	
Child Support	
Unemployment	
SSI	
Social Sec. Disability	
Other	
Total Income	

flint hills community clinic

"Our community, Our Clinic"

PATIENT HOUSEHOLD MEMBERS

5. Name: _____ D.O.B: _____

Relation: _____

Sex
- ☐ Male
- ☐ Female

Race
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian/Pacific Island
- ☐ Multi-Racial
- ☐ Pakistan
- ☐ Other
- ☐ Unknown

Employment
- ☐ Disabled
- ☐ Employed - FT
- ☐ Employed – PT
- ☐ Minor
- ☐ Retired
- ☐ Student
- ☐ Unemployed

Monthly Income

Salary/Wages	
Child Support	
Unemployment	
SSI	
Social Sec. Disability	
Other	
Total Income	

Monthly Income

	Patient	Others in Household
Salary/Wages		
Child Support		
Unemployment		
SSI		
Social Sec. Disability		
Other		
TOTAL HOUSEHOLD INCOME		

flint hills community clinic

"Our community, Our Clinic"

PATIENT HISTORY

Please check all that apply to the patient

- ☐ Allergies
- ☐ Anemia anticoagulation
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding
- ☐ Blood Plasma
- ☐ Bowel Disease
- ☐ COPD
- ☐ Depression
- ☐ Dental Disease
- ☐ Diabetes
  - ☐ Type I
  - ☐ Type II
- ☐ Diarrhea
- ☐ Eye Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ Gout
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Back Pain
- ☐ Major Blood Vessel Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Multiple Sclerosis or Nerve Disease
- ☐ Musculoskeletal Disorder
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Obesity
- ☐ Peripheral Arterial Disease
- ☐ Prostate
- ☐ Thyroid
- ☐ Transfusions
- ☐ Skin disorder
- ☐ Sleep Apnea
- ☐ Stroke

INFECTIOUS DESEASES

- ☐ AIDS of HIV
- ☐ Cholera
- ☐ Chicken Pox
- ☐ Dengue
- ☐ Ebola
- ☐ Encephalitis
- ☐ Guinea Worm
- ☐ Hepatitis
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ Parasite Infection
- ☐ Poliomyelitis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tetanus
- ☐ Trachoma
- ☐ Tuberculosis
- ☐ Whooping Cough

Cancer (Type):		Date:
Heart Disease:		Date:
Venereal Disease (Type):		Date:
Surgery:		Date:
Surgery:		Date:
Hospitalization:		Date:
Hospitalization:		Date:

flint hills community clinic

"Our community, Our Clinic"

PATIENT CURRENT MEDICATIONS

1. Drug Name:		Taken For:	
Sig:		Dose:	
Prescriber Name:		Pharmacy:	
2. Drug Name:		Taken For:	
Sig:		Dose:	
Prescriber Name:		Pharmacy:	
3. Drug Name:		Taken For:	
Sig:		Dose:	
Prescriber Name:		Pharmacy:	
4. Drug Name:		Taken For:	
Sig:		Dose:	
Prescriber Name:		Pharmacy:	
5. Drug Name:		Taken For:	
Sig:		Dose:	
Prescriber Name:		Pharmacy:	
6. Drug Name:		Taken For:	
Sig:		Dose:	
Prescriber Name:		Pharmacy:	

"Our community, Our Clinic"

Flint Hills Community Clinic 401 Houston Street, Suite C Manhattan, KS 66502 Ph: (785) 323-4351 Fax: (785) 323-4359

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient/ Previous Names _____ DOB _____

Street Address _____ Current Phone Number _____

AUTHORIZES FLINT HILLS COMMUNITY CLINIC TO OBTAIN RECORDS FROM:

Name of Health Care Provider/Other _____

Street Address _____

City, State, ZIP _____

Provider Phone or Fax Number _____

AUTHORIZES FLINT HILLS COMMUNITY CLINIC TO RELEASE TO:

Name of Health Care Provider/Other _____

Street Address _____

City, State, ZIP _____

Provider Phone or Fax Number _____

INFORMATION TO BE DISCLOSED: *identify below the specific information you are authorizing to be disclosed:*

☐ Discharge Summary ☐ H&P ☐ Diagnostic Report (lab, x-ray, etc.) ☐ Operative Report ☐ Diagnosis & Medications
☐ Complete Health Record ☐ ER Report ☐ Other: _____

For the following Dates: From: _____ To: _____

PURPOSE FOR DISCLOSURE: ☐ Continued Care ☐ Referral for Services ☐ Other:_____

Additional Notes/Comments:_____

_____

_____ Authorization for verbal communication with the above-listed person or agency regarding treatment/records (please initial, if applicable)

YOUR RIGHTS REGARDING THIS RELEASE OF INFORMATION: I understand that I have this authorization is voluntary. I understand that I do not need to sign this form in order to ensure healthcare treatment, payment or eligibility for benefits. I understand that under state and federal confidentiality, only the information specified in this authorization can be released to the person or agency indicated. I understand that if the person or organization listed above is not a healthcare plan or provider, federal privacy laws may no longer protect the release of information. I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Flint Hills Community Clinic. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is valid until the following date(s) _____or for one year from the date signed.

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE **DATE OF AUTHORIZATION**

FOR OFFICE USE ONLY

☐ ROI Mailed ☐ROI Faxed Date Sent: _____

Date Received by FHCC: _____ Processed by: _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE **DATE OF AUTHORIZATION**

"Our community, Our Clinic"

Flint Hills Community Clinic
Patient Agreement and Treatment Policies

Eligibility

Flint Hills Community Clinic (hereafter known as FHCC) will treat individuals who meet the following eligibility requirements:

- Uninsured (no health benefits or coverage, including Medicaid, Medicare or 3rd party insurance) Resident of Riley County and/or the City of Manhattan.
- Household income is at or below 200% of the federal poverty level.
- Patients will be required to provide the clinic with proof of residency and household income annually.

The clinic reserves the right to request documentation of a patient's eligibility at any time. If a patient no longer meets the eligibility requirements, the clinic will no longer provide services to that individual. Eligibility updates are required annually.

Services

All patients at FHCC are seen by a Physician, Physician's Assistant (PA), Nurse Practitioner (ARNP) or other licensed professional in the state of Kansas. Services are provided free of charge and include primary and acute health care. FHCC cannot treat emergencies or pregnancies. Payment for medical treatment sought outside of the clinic, including emergency room visits, will be the sole responsibility of the patient.

Medications

FHCC is not responsible for the payment of patients' prescriptions. Samples may be given to patients to begin treatment at the digression of the provider. Patients are responsible for obtaining any ongoing medications and the cost associated with each prescription. FHCC does not have stock medications on site for distribution to its patients. Enrollment for various assistance programs through individual pharmaceutical companies may be available to patients for ongoing prescriptions.

Prescription Refills

Patients are responsible for notifying their pharmacy when they are in need of a refill. Patients should call their pharmacy no less than TEN DAYS before a medication runs out. FHCC providers will NOT prescribe controlled substances.

PAP

(Prescription Assistance, Eligibility Required)
Patients are responsible for notifying FHCC when they are in need of a refill. Patients should call no less than THIRTY DAYS before a medication runs out.

Referrals

Referrals to specialty physicians are made only when deemed medically necessary by one of our providers. These referrals are made only as available and are not guaranteed. Patients may be responsible for a co-pay or a portion of the cost of these visits and will be required to show documentation of household income. It is the responsibility of the patient to contact the referred specialist regarding their costs prior to the consultation appointment. The patient must also check to see if financial assistance is available.

Patient Attendance Policy

Patients are expected to notify FHCC if they cannot keep a scheduled appointment. Notification of a cancelled appointment is to occur by NOON on the day of the appointment for evening appointments or by 4 pm on the day prior for afternoon appointments. This will allow us to schedule patients on our waiting list.

"Our community, Our Clinic"

No-Show Policy

The first time a patient no-show's, that patient will be required to speak with a Social Service person before another appointment to see a provider will be made. A second no-show will result in a 90 day suspension from FHCC. A third no-show the patient will be dismissed from FHCC. The No-show policy also applies to specialty care referrals.

Privacy Policy

All FHCC staff and volunteers operate according to HIPAA rules and regulations. Written consent is required to release any patient information to other persons or agencies, except as required by law in the cases of court orders, child abuse, life threatening situations and national security issues. Patients' demographic information may be used for the purpose of statistics in reporting to funding sources.

Reporting Policy

FHCC staff and volunteers are required by law to report any suspicion of child, adult, elder or vulnerable person abuse including neglect, emotional, physical or sexual abuse.

Please initial each of the following statements to acknowledge that you have read them and agree to them:

_____ Flint Hills Community Clinic is not an insurance carrier. FHCC operates under the KDHE 's Charitable Care Health Program and through the generous donations of volunteer medical providers.

_____ I will notify the clinic no later than one hour prior to an appointment if I cannot keep my scheduled appointment. I understand that if I do not, I will be subject to FHCC's "No Show" policy.

_____ I understand that services provided at the clinic are free of charge. I understand that if I am referred to a specialist I may be responsible for assessed fees. I understand that if I seek medical services outside of the clinic, including the Emergency Room, that I will be responsible for any bills incurred.

_____ I understand that I am expected to treat FHCC staff and volunteers with respect. If I am uncooperative, verbally or physically abusive, intoxicated or behave in an inappropriate manner, I may be dismissed as a patient from FHCC.

_____ I understand that I am expected to be truthful with FHCC staff and volunteers about other medical services that I am receiving and medications or behaviors that may affect my medical well-being.

_____ I understand that FHCC treats individuals who meet the eligibility parameters. I understand that I am responsible for being truthful about my residency, income and insurance status and that if I provide false information about my eligibility that I will be dismissed as a patient from FHCC.

_____ I understand that I am responsible for monitoring my prescriptions and that I need to contact the pharmacy no less than ten days before my prescription runs out. If I am a PAP patient, I am responsible for contacting the clinic no less than thirty days before my prescription runs out. I understand that if I contact the pharmacy within less than ten days, or the clinic within less than thirty days of my prescription running out that I am not guaranteed a refill before my medication runs out.

_____ I understand that the Board of Directors policy of the Flint Hills Community clinic is that NO prescriptions or refills for medications which are classified "Scheduled II, Scheduled III, Scheduled IV, Scheduled V" will be provided by physicians, nurse practitioners, or physician assistants.

"Our community, Our Clinic"

I have received a copy of the clinic's Patient Agreement and Treatment policies and I understand and agree to all of the above. I understand that if I violate any of the above-stated agreements, I may be terminated as a patient of the Flint Hills Community Clinic.

_____ _____

Patient or Guardian's Signature Date

By signing below, I acknowledge that I have no health coverage, including Kansas Medicaid, Health Wave, Medicare or any private insurance (including catastrophic coverage and insurance with high deductibles). I will notify Flint Hills Community Clinic immediately if I obtain any health benefits and understand that once I am covered under a health coverage plan that I am no longer eligible to receive services at Flint Hills Community Clinic.

_____ _____

Patient or Guardian's Signature Date

By signing below, I give Flint Hills Community Clinic permission to verify with Social and Rehabilitation Services that I do not have any health coverage provided through the state of Kansas through Medicaid, Health Wave, or any other government-issued health benefits and to verify with my employer or my spouse's employer that I do not have health insurance or benefits through the employer.

_____ _____

Patient or Guardian's Signature Date

Revised 10/30/12

flint hills community clinic

"Our community, Our Clinic"

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Date: _____

Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call: ☐ my home: _____ ☐ my work:_____ ☐ my cell: _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ _____

Best time to reach me is: (day) _____ between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

flint hills community clinic

"Our community, Our Clinic"

ATTENTION FHCC PATIENTS

The clinic is authorized to provide care to medically indigent persons, those who have no access to health care via insurance or government programs and whose income is less than 200% of the current government standards.

The provision of income information such as pay vouchers, unemployment benefits, or other income is essental to insure we meet these requirements.

If you have indicated that you have no income, please provide a statement below which explains how you are meeting your needs. How do you pay for housing, food and other needs?

Signature: _____ Date: _____