Today's Date: ______________________

Hope Center
10274-A Hwy 104
Fairhope, Al. 36532

Name: ____
First MI Last

Address: ______________________ City______________ State & Zip______________ Email:______________

Home# (___)______________ Cell# (___)______________ **Pharmacy Name-Location and #**______________

Date of Birth: ______________ **Sex:** ❑ Male ❑ Female **Social Security Number:** ______________

Race/Ethnicity: ❑African American ❑White ❑Native American ❑Asian ❑Latino/Latina ❑Other (specify):__________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other (specify):______________

Employment Status: ❑ Employed ❑ Unemployed **Number of hours worked each week:**_____

Employer's Name:______________________________ **Employer Phone #** ______________

Health Insurance: ❑ None ❑ Medicaid ❑ Medicare ❑ Other ______________

Please Provide 2 Emergency Contacts

Next of Kin/Emergency Contact:______________________ **Phone:**(___)__________ **Relationship:** ________

Emergency Contact:______________________ **Phone:**(___)__________ **Relationship:** ________

Church Affiliation:____

Referred by: ❑Physician ❑Dentist ❑Friend/Family ❑Hospital ❑Media ❑Yellow Pages ❑Church______________ ❑Other (specify):______________

Primary Care Physician: ______________________ **Physician Phone:** (___)______________

Have you been to the Emergency Room in the last 12 months? ❑Yes ❑No
If yes, which hospital ______________________ Month/Year __________/__________

COMPLETE IF PATIENT IS A CHILD UNDER 18:

Name of Responsible Party: ______________________________

Social Security Number: ______________ **Date of Birth:** ______________

❑**Same as Above** or **Street Address:** ______________________ **City:** ______________ **Zip:** ________

Home Phone: ______________ **Work Phone:** ______________ **Other Phone:** ______________

The above information is true to the best of my knowledge. I understand that I am financially responsible for the balance of any office visits. By signing below I am stating I have no insurance of any kind. I also authorize Hope Center, Inc. to release or obtain any information required to establish my status as a client/patient.

Signature:______________________________________ Date:______________

Signature of Parent/Guardian: ______________________________ Date:______________

Hope Center Witness:______________________________ Date:______________

Personal History

Today's Date ________________

Name ____________________________________ DOB _____/_____/______

Reason for today's visit ____

List any medical problems you may have (i.e. diabetes, cancer, heart or breathing problems, etc.)

____

____

Current Medications: (please list) ____

Medication Allergies: ___________________________________ Food Allergies: ___________________

Circle any surgery you have had: Appendectomy Gallbladder Hernia Repair Heart Surgery

Hysterectomy Tonsillectomy Other _______________________

Do you smoke? Yes No How many packs per day? ___________________

Do you drink alcohol? Yes No How much and how often? _________________________

Check any of the conditions below that you have or have had in your family health history. Please note in "self" column or note family relationship (father, mother, grandfather, grandmother, brother, sister, etc.)

Self		Family		Self		Family	
☐	Allergies/Hay Fever	☐	______________	☐	Headaches	☐	______________
☐	Sinus Problems	☐	______________	☐	Seizures	☐	______________
☐	Asthma	☐	______________	☐	Stroke	☐	______________
☐	Emphysema	☐	______________	☐	Indigestion	☐	______________
☐	Tuberculosis	☐	______________	☐	Ulcers	☐	______________
☐	Heart Attack	☐	______________	☐	Bowel Problems	☐	______________
☐	Chest Pain	☐	______________	☐	Kidney Stones	☐	______________
☐	Irregular Heartbeat	☐	______________	☐	Kidney Failure	☐	______________
☐	High Blood Pressure	☐	______________	☐	Kidney Infection	☐	______________
☐	Arthritis	☐	______________	☐	Diabetes	☐	______________
☐	Muscle Weakness	☐	______________	☐	Cancer	☐	______________
☐	High Cholesterol	☐	______________	☐	Anemia	☐	______________

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Nurse Signature

This is a contract between Patient, Dentist, Physician and HOPE Center.

HOPE Center Policy and Procedure regarding Narcotics and Benzo's, effective March 13, 2013.

This includes but is not limited to Lortab, Soma, Klonopin, Xanax, Lithium, Adderall.

Narcotics and Benzo's are temporary medications and not used or filled on a chronic basis at HOPE Center. HOPE Center is not a pain clinic or a mental health clinic. Therefore, all narcotics and benzo's will be written for one month at a time. If the patient is not able to wean off these drugs after the crisis period is over, the patient will be referred to a pain clinic or mental health clinic. HOPE Center is not responsible for the care of long term treatment of pain medications or psychotropic medications.

In the event of a patient, losing their medication or prescription, medication or prescription being stolen, self medicating, or in any way not follow the doctor's orders. The patient will not be given a refill and will be referred immediately to another doctor or facility.

I, ______________________________ have read and understand the above contract regarding the HOPE Center policy and procedures of narcotic and benzo medications.

Patient signature: ______________________________ Date: ______________

HOPE Center Witness: ______________________________ Date: ______________

Comments:

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CONSENT FOR TREATMENT

I give consent for ____to be seen at Hope Center; whether it be for medical, dental or counseling for evaluation and treatment. (If you are the patient, please sign for yourself).

Signature____Date_____________
Relationship to Patient____________________________________

I____do hereby give Hope Center and parties designated by Hope Center, the right to use my image or photo in publications or promotional materials and displays.

Signature____Date_____________

RECORD OF HIPAA NOTIFICATION

I have read the Notice of Privacy Policy and Practices of the Hope Center.

Signature____Date_____________
*If you would like a copy of the Privacy Policy and Practices please notify the receptionist.

EMERGENCIES

I understand the Hope Center Medical and Dental Clinic is staffed by professional doctors and dentists who volunteer their time. Due to this fact, the Hope Center has limited operating hours and does not provide after hours services. In the event of an emergency, call 911 or proceed to the nearest hospital emergency room. After business hours, Hope Center phones are answered by a voice-mail system and messages are not retrieved until the next business day.

Signature____Date_________________

PATIENT AGREEMENT

Hope Center is a private (non-governmental), non profit agency which is designed to provide health care MEDICAL, DENTAL and COUNSELING to non-insured, under-served families in Baldwin County and the surrounding areas.

To better serve you, we ask for your cooperation in following the policies listed below. If you are unable to follow these guidelines, or find them unacceptable, another health care provider may be better able to meet your needs.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I will inform Hope Center if my address, telephone number(s), income within 30 days of any change.
2. I will give Hope Center 24 hours notice if I will be unable to keep my appointment.
3. If I miss three appointments without notifying Hope Center, I understand that I may no longer be able to receive services at the Center.
4. I understand that my charges per office visit are due at the time of service. I also understand that if I schedule a doctor's appointment and I am unable to pay my office fee, I will call Hope Center 24 hours prior to my appointment.
5. I do hereby authorize the administrative staff of Hope Center to disclose any personal health information to other health care professionals, when medically necessary.
6. I do hereby authorize the administrative staff of Hope Center to disclose my registration and screening information for purposes of obtaining health care at another facility.
7. I understand that only referral appointments made by Hope Center staff for me at other health care facilities will be at a discounted rate and/or free of charge. If I schedule an appointment or choose to see any other health care provider without approval from Hope Center, I will be responsible for the bill and I may lose my eligibility for obtaining health care at another facility.
8. I understand that I may choose to seek treatment, with any doctor of my choice, at any emergency room and that if I do so I will be responsible for the bill.
9. If I have any questions about an appointment or treatment, I will contact Hope Center. For each outside appointment I will present the forms that I have been given at Hope Center to the place of service.
10. I am solely responsible for following through on testing and treatment ordered by providers at the Center. I understand that if I fail to follow the physician's or dentist orders my treatment may be unsuccessful.
11. I understand that if I am uncooperative, verbally or physically abusive, intoxicated or behaving in an inappropriate manner, I will not be eligible for services at Hope Center.
12. I understand that the Hope Center is a nonprofit organization/clinic therefore, I will not sue or press charges toward any medical or dental professional or volunteer associated with the Hope Center.

I have received a full explanation of the Center's services and I understand and agree to all of the above. I understand that I can be terminated from the Center if I have given wrong or misleading information or if I fail to follow the policies above.

Patient's Signature____ Date____________

Interviewer's Signature______________________________________Date____________