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	☐	______________

____

Nurse Signature

PATIENT AGREEMENT&CONTRACT/CONSENT FOR TREATMENT/EMERGENCY NOTICE

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 of any and all medical, dental and counseling providers I am currently seeing while a patient at the Hope Center. ________
2. I will inform Hope Center of all current medications at each visit. ________
3. I will inform Hope Center within 30days, if my insurance status, address, telephone number(s), or income changes. ________
4. I understand if I miss three appointments without notifying Hope Center, I may no longer be able to receive services. ________
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 and to disclose my registration and screening information for purposes of obtaining health care at another facility. ________
6. I understand outside of the Hope Center any referral or other provider's fee is between the patient and that provider. Hope Center is not responsible. ________
7. I am solely responsible for following through on testing and treatment ordered by providers at the Hope Center. I understand that if I fail to follow the physician's or dentist orders my treatment may be unsuccessful. ________
8. 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 and will be discharged as a patient. ________
9. I understand that the Hope Center is a nonprofit organization/clinic/agency therefore; I will not seek legal action or recourse towards any volunteer(s) or staff associated with the Hope Center serving in a professional capacity or otherwise. ________
10. I give consent for ________________________________, to be seen at Hope Center; whether it be for medical, dental or counseling for evaluation and treatment.
    Signature:____ Date: ______________

11. 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.

12. EMERGENCIES: **<u>HOPE CENTER MEDICAL, DENTAL AND COUNSELING IS NOT AN EMERGENCY FACILITY.</u>** I understand the Hope Center Medical, Dental and Counseling Clinic is staffed by professional doctors, dentist and counselors who volunteer their time. After business hours, Hope Center phones are answered by a voice-mail system and messages are not retrieved until the next business day. Due to this fact, *<u>the Hope Center has limited operating hours and does not provide after hours services.</u>* In the event of an emergency, call 911 or proceed to the nearest hospital emergency room.
    Signature: ____ Date: ______________

13. CONTRACT BETWEEN PATIENT, DENTIST, PHYSICIAN, COUNSELOR AND HOPE CENTER.
    <u>Hope Center Medical is not a pain clinic or a mental health clinic. Therefore, Hope Center Medical does not write narcotics and/or benzodiazepines.</u>
    In the event a dentist needs to write for pain medication they will be limited to 16 tablets. We do not refill. If the dental patient feels the need for more pain medication they will be required to make an appointment and see the next available dentist for follow up.
    I, ____ have read and understand the above contract regarding the Hope Center policy and procedures of narcotics and benzodiazepines medications.
    Signature: ____ Date: ______________

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

Signature: ____ Date: ______________
Hope Center Witness: ______________________________ Date: ______________