SHEPHERDS CARE MEDICAL CLINIC

New Patient Eligibility Form

Name: _____
Last *First* *M.I.*

Social Security Number or Government ID: _____

Birth Date: Marital Status:

Employer: Work Phone:

Insurance Information

	Yes	No
Have you applied for the Affordable Care Act Insurance	☐	☐
Does your employer offer health insurance?	☐	☐
Do You have Medicare?	☐	☐
Do you have Medicaid?	☐	☐
Do you have private Insurance?	☐	☐
Do you have Veteran Administration Assistance?	☐	☐
Are you a patient of any of the following:	☐	☐
Alliance Medical Ministry, Urban Ministries, Etc.	☐	☐

Proof Of Income Sources:

- ☐ Pay Stubs
- ☐ Child support
- ☐ Food Stamps
- ☐ 1040 Income Tax Forms
- ☐ Alimony (any Income)
- ☐ Unemployment Check Stub
- ☐ Social Security (Include Children)
- ☐ Other source of income: need Notarized statement from source.

Household Members and Income: (List all in home)

Who		Name	Date of Birth	Source of Income	Monthly	Yearly
Patient						
Spouse						
Dependent	Relation:					
Dependent	Relation:					
Dependent	Relation:					
Dependent	Relation:					
			Total Income			

200% of the Federal Poverty Level

Family Size	Monthly Income	Gross Annual Income
1	$1,961	$23,540
2	$2,655	$31,860
3	$3,348	$40,180
4	$4,041	$48,500

For each additional person add $8,320

_____ Patient qualifies for SCMC Services.

_____ Patient does not qualify for SCMC services

I agree that the financial information given is correct.

Patient Signature _____

Witness _____

Date _____

Shepherds Care Medical Clinic

304 B Pony Road, Zebulon NC 27597

Date: _____ DOB _____

Name:
Nombre
_____
Last / Apellido *First / Primer* *M.I./ Inicial*

Address:
Dirección
_____
Street Address / Calle *Apartment/Unit #*

_____
City / Ciudad *County:* *State* *ZIP Code/Codigo*

Home Phone
Teléfono _____ Social Security Number:
Numero de Segura Social _____

Do you have medical insurance, Medicare or Medicaid?
¿Tiene usted seguro medico, Medicare o Medicaid? ☐ Yes/ *Si* ☐ No / *No*

Reason for visit / *Razón de su visita*

☐ Diabetes / Hypertension *Diabetes /Hipertensión* ☐ Primary Care/ *Medicina Primaria*
☐ Gynecology /PAP *Ginecología / PAP* ☐ Other / *Otro*

Do you have an immediate medical need? / *¿Necesita atención médica inmediata?* ☐ Yes/ *Si* ☐ No / *No*

Why? / *¿Porque?* _____

Are you… / *Esta usted…*

☐ Employed / *Empleado* ☐ Unemployed / *Sin empleo* ☐ Retired / *Jubilado*
☐ Disabled / *Disabilitado* ☐ Student / *Estudiante* ☐ Other / *Otro*

Name and address of employer
Nombre y dirección de empleador _____

Race / *Raza*

☐ American Indian/Alaskan ☐ Asian/Pacific Islander ☐ Black/African American
☐ Hispanic/Latino ☐ White/Caucasian ☐ Other / Otro

Country of origin / *País de origen* _____ **County you live in:** _____

Language Preference / *Idioma Preferido* _____

Do you need an interpreter? / *¿Usted necesita intérprete?* ☐ Yes / *Si* ☐ No / *No*

Gender / *Género*

☐ Female / *Femenino* ☐ Male / *Masculino*

Marital Status / *Estado Marital*

☐ Single / *Soltero* ☐ Married / *Casado*
☐ Divorced / *Divorciado* ☐ Widowed / *Viudo*

Do you live… / *Usted vive…*

☐ Alone / *Solo* ☐ With spouse / *con esposo* ☐ With children / *Con hijos*
☐ With family / *Con familia* ☐ Other / *Otro* **Own** _____ **Rent** _____ **County** _____

Spouse Name / *Nombre de esposo(a)* _____

Emergency Contact / *Contacto de emergencia* _____
Name / Nombre

_____
Telephone / Telefono

Shepherds Care Medical Clinic is a free health clinic for low-income, uninsured adults. We will ask for documentation of your income.

Clínica Shepherds cari medíca clínica gratis para adultos de bajos ingresos, sin seguro medico. Nosotros pediremos de Salud Comunitaria documentación de sus ingresos.

Shepherd's Care Medical Clinic
Patient Agreement

Program Overview

Area physicians and Shepherd's Care Medical Clinic are volunteering their services to help you get well and stay well. This is not a government program or an 'entitlement'. Shepherd's Care Medical Clinic seeks to link Wake, Johnston, Nash and Franklin County residents with a medical home so that health services can be received on a regular basis. Shepherd's Care Medical Clinic does not cover non-emergent care in the emergency room or ambulance services. By signing this form, you authorize Shepherd's Care Medical Clinic to verify your financial and residency information realizing that this program may be stopped should funding not be available.

Program Benefits

When enrolled in Shepherd's Care Medical Clinic you will be provided a medical home. Other benefits include:

- Access to a medical home that knows you and will provide well and sick care.
- Access to a medication assistance program (for long-term, chronic medicines).
- Access to lab and diagnostic services arranged by your regular doctor/medical home.
- Limited access to appropriate specialist referrals arranged by your regular doctor/medical home.

Patient Responsibilities

You understand/agree that:

_____1.Specialty referrals will be arranged by your regular doctor/medical home as needed for your care. Limited specialty care appointments are available and given on a first come first serve basis and may have waiting list.

_____2.You will keep every medical appointment or give at least 24 hours' notice to cancel. You will be on time for your appointment and show your appreciation by saying thank you to the provider.

_____3.You will follow your treatment plan. For example, get prescribed medicines and take as directed.

_____4.You will promptly supply any information that may be requested by the program.

_____5.You will remain aware of the expiration date of your eligibility in this program

_____6.You will immediately contact Shepherd's Care Medical Clinic if your income changes or if you become covered by **Medicare, Medicaid, private insurance or other health insurance or medical benefits**.

_____7.You will contact Shepherd's Care Medical Clinic immediately with any change in address and/or telephone number.

_____8. During the duration of your enrollment you will allow all financial and health information to be shared with other individuals, organizations and agencies solely at the discretion of Shepherd's Care Medical Clinic.

_____9.You must provide all documents or information needed by other agencies such as Health Services or Department of Social Services in order to obtain Charity Care

By signing below, I confirm that I understand and agree to the above conditions. I also understand that if I do not follow the Patient Responsibilities listed, then I will be discharged from the clinic. Questions, please call 919-404-2474

Patient Signature: _____
Address_____

Print Name: _____ Date_____ Email address:_____

By signing below, I confirm that I nor my spouse (if living in the home) have no income coming into the home at this time. This includes earned income, social security payments, unemployment benefits, etc.

Patient Signature:_____
Date:_____

Shepherd's Care Medical Clinic

CONSENT TO TREATMENT, RELEASE AND ACKNOWLEDGEMENT FORM

Patient Name: _____

CONSENT TO TREATMENT

I request those physicians and other healthcare professionals who care for me to perform routine examinations, diagnostic procedures, hospital care and therapeutic treatments, which in their judgment, become necessary while I am a patient of the Shepherd's Care Medical Clinic. Routine diagnostic procedures and medical treatments include but are not limited to ECGs, x-rays, physical therapy, blood tests and administration of medications. I also consent to medical recording or filming necessary in the judgment of my physician, to document the course of my injury or illness and to provide appropriate medical care, performance improvement and education. I acknowledge that I have the right to request stopping of any recording or filming during the filming and up until a reasonable time before the recording or film is used.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the Shepherd's Care Medical Clinic to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I understand that Shepherd's Care Medical Clinic, in order to deliver quality healthcare, develops and maintains health information which may include physician notes, history and physical, medication reports, tests and test results, and treatment plans. I concur that this health information is used for the following:

- care and treatment plans
- communication between interdisciplinary healthcare providers
- quality control by Shepherd's Care Medical Clinic

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Physician Practice's Notice of Privacy Practices ("Notice"). I understand that information Shepherd's Care Medical Clinic acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the Notice or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

_____ _____

Signature Witness

_____Patient _____Substitute Decision Maker _____**DATE COMPLETED**

_____ _____

If Substitute Decision Maker, state relationship If Substitute Decision Maker, state reason

Shepherd's Care Medical Clinic

Serving the uninsured one person at a time

Dear Patient,

We are very glad that you have chosen to come to Shepherd's Care Medical Clinic for your medical care. We are a free clinic in that we do not charge for being seen by any of the health care providers.

One of the services we provide is labs, drawing blood and sending your blood to Rex Laboratories for evaluation. Shepherd's Care has a partnership with Rex for a very low cost to do your lab work. We ask that you consider donating the cost of the labs. By doing this it helps us stretch the already tight budget we have, so we can keep the doors open to serve you and others like you who have medical needs and no insurance.

If you have any questions, please feel free to ask at any time.

Thank you for your help.

Sincerely,

Leona Doner
Executive Director
Shepherds Care Medical Clinic

I acknowledge that I have read and understand the above letter.

Patient: _____ Date: _____

304 B Pony Rd., Zebulon, NC 27597
Office: 919-404-2474 Fax: 866-929-4189