**1. PATIENT INFORMATION FORM**

NAME Last _____ First _____ Birthdate ____/____/____

ADDRESS Street _____ City _____ State _____ ZIP _____

PHONE Home _____ Work _____ Cell _____

GENDER ☐ Male ☐ Female ☐ Other SS# _____ Email _____

EMPLOYMENT STATUS ☐ FT work ☐ PT work ☐ Not employed ☐ FT student ☐ PT student

EMPLOYER(S) _____

EMERGENCY Contact _____ Phone _____ Relation _____

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**2. NWOSC HIPAA FORM #.300.502**

In general, the HIPAA privacy policy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

Oral Communication:

☐ Home telephone
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work telephone
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

Written Communication

☐ Okay to mail to my home address

☐ Okay to mail to my work address

☐ Okay to fax to this number _____

☐ Other _____

☐ I permit the CommunityCare Free Medical Clinic to discuss my PHI (including prescriptions) with and to disclose my PHI to the following individuals:

- ☐ My spouse _____
- ☐ My adult child _____
- ☐ My parent _____
- ☐ My personal representative _____
- ☐ Other _____

☐ If checked the following instructions apply: _____

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**3. ACKNOWLEDGEMENT**

I have read the foregoing Notice of Privacy Practices provided to me by the CommunityCare Free Medical Clinic (CCFMC), and I have been given the opportunity to discuss the CCFMC privacy practices. I understand CCFMC may, at its discretion, change the terms and conditions of this Notice. Any questions I had, have been answered to my satisfaction. Understand the content of the Notice of Privacy Practices and have been provided with a copy of same.

→PRINT NAME _____ SIGN NAME _____ DATE _____

The NPP was provided to _____, however he/she did not acknowledge receipt for the following reason: ☐ refused ☐did not understand ☐ other _____

STAFF SIGNATURE _____

***Please turnover to complete other side.***

**PATIENT WAIVER AND AUTHORIZATION**

I affirm that I do not receive General Assistance, Medicaid or Medicare benefits, and that I have no other health care benefit eligibility.

1. I hereby authorize the staff of the CommunityCare Free Medical Clinic and those to whom they may refer me or designate as assistants, to render to me general medical, dental, audiological, vision and social care.

2. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such treatments and examination. I agree to hold the CommunityCare Free Medical Clinic and its affiliates blameless for any injuries or complications resulting from or attributable to such treatments and examinations.

3. I understand and agree that the CommunityCare Free Medical Clinic shall not be responsible for loss of any money, valuables, or other personal effects brought to the clinic site.

4. I have received a copy of the basic clinic patient policies and agree to follow them. I understand that failure to follow these policies can result in termination of medical care to me by the CommunityCare Free Medical Clinic.

5. I understand and agree that the personal information provided may be verified by contacting relevant individuals and organizations.

6. In your efforts to provide me with continuing medical care, I hereby authorize the CommunityCare Free Medical Clinic to release any of my medical records as they determine to be in my best interest in providing me continuing medical care and attention.

7. I understand that once I no longer meet the financial eligibility provisions of this program, the CommunityCare Free Medical Clinic will automatically terminate my eligibility to receive medical care and attention from this program.

8. I understand that any person who knowingly and with intent to defraud or deceive, gives false information or omits important facts regarding qualification to receive free care at the CommunityCare Free Medical Clinic may be guilty of a criminal act and will be subject to criminal persecution.

9. I understand and agree that if I fail to keep any schedule appoints at the CommunityCare Free Medical Clinic or any referral appoints with having first given at least 24 hours notice of cancellation, I will forfeit any and all rights and privileges to patients of the CommunityCare Free Medical Clinic and my registration will be immediately cancelled.

**I understand that by signing this waiver, I have full knowledge that I am giving informed consent to the provision of diagnosis, care, or treatment and neither I, nor any of my heirs, successors or assignees will bring a tort or other civil action including a medical malpractice claim unless the action or omission of the healthcare professional constitutes willful or wanton misconduct.**

By signing below, I certify under penalty for fraud that the information in this statement and on the "Patient Information Form" is accurate and true, and that I agree to all of the conditions and terms listed in numbers (1) through (9) above.

Patient signature _____ Date _____

Parent / legal guardian signature _____ Relationship _____

Witness _____

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**4. PARENT OR LEGAL GUARDIAN CONSENT FOR A MINOR**

I consent for clinic staff to examine, order tests and render medical care for my child. This consent remains in force until such time that the parent or legal guardian withdraws consent (in writing) or the minor reaches the age of maturity.

Parent/legal guardian _____ Date _____

Witness _____