

HEART AND SOUL REGISTRATION FORM

(Please Print)

524 S. 16									
Today's date:									
		P/	ATIENT IN	FORMA	TION				(645)
Patient's last name:		First:		Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.			(circle one) / Div / Sep / Wid
Is this your legal name? ☐ Yes ☐ No	If not, wha	it is your legal name?	(Former nam	ne):	Birth dat	e: (Mon/Day	200 200		Sex:
Street address:			Cell phone#:					ome phone #:	
P.O. box:			e:		ZIP Code:				
		4540000	URANCE	INFORM	ATION	7954 C 15			
Is this patient covered by	insurance?	☐ Yes ☐ No	ORIZATIO	N FOR M	FCCACE			ADEC: HER	
	• The He	eart and Soul Clinic e	e-mail is a no			em akaneka ka	y in the second		
Name of local friend or re	lative:		Relationship to patient:		Home phone #:			Work ph	none #:
					())
You may <u>release</u> me	edical informa	ation to the following:		Relationshi	р	Phor	ne		
Name				Relationshi	p	Phor	ne		
The above inform	nation is tr	ue to the best of I	my knowled	lge.					
Patient Signatu	ı re (paren	t signature if patier	nt is under 18	3 years old)	-	NS-19-53-5	Date	



Thank you so much for visiting the Heart and Soul Free Clinic! Your answers to the following questions aid us in securing the grant funding that allows us to provide free medical and dental care. All of your answers will be kept strictly anonymous, so please answer as accurately as possible.

Today's Date//_	<u></u>						
Patient Name:			Patient's Dat	e of Birth:	/	_/	
Patient's Gender: FEMALE	MALE OTH	ER:		Mor	nth Day	Year	
Patient's Zip Code:		F	atient's Cou	nty:			
1) In the last year, has the patien	nt struggled to s	ecure immediate	and or affor	dable mental	health care	e? YES	NO
2) Is there an individual in the pa	tient's househo	ld who is disable	d or handicap	ped?	YES	NO	
Is the patient be	ing seen disable	ed? YES	1	NO			
3) Patient's marital status:	MARRIED	SINGLE	WIDOW/	WIDOWER			
4) Does the patient work:	FULL-TIME	PART-TIME	UNE	MPLOYED	DOES	NOT APPLY	
5) Does the patient struggle with	transportation	for things like red	eiving medic	al care and w	orking?	YES	NO
6) Patient's current housing situa	tion: RENT	OWN DO	S NOT HAVE	HOUSING	OTHER:		
7) In the last 6 months, has the p	atient been una	able to pay for or	obtain food?	YES		NO	
8) In the last 6 months, has the p	atient been una	able to pay their u	tilities?	YES	NO	DOES NOT	APPLY
9) Has the patient being seen rec	eived assistance	e from their town	ship trustee	in the last 12	months?	YES	NO
10) Is the patient a U.S. Veteran?	YES	NO					
11) Does the patient smoke?	YES	NO					
Secretary Politics (Supplications resource) from the exposite action was described with the secretary and the secretary							
Does the patient vape?	YES	NO					
If yes, would the patient	like to receive a	referral for the I	ndiana Smok	ing Cessation	Program?	YES	NO
12) In the last 6 months, has the	p atient experiei	nced any concern	s with drugs	or alcohol?	YES		NO
13) Does the patient being seen I	nave medical ins	surance?	YES	NO			
If yes, what type? (i.e M	edicare, Medica	aid, Employer): _					
14) Does the patient being seen h	nave a Primary (Care Physician?	YES	NO			
15) Does the patient being seen h If yes, what type? (i.e			YES	NO			

Please Turn Page to the Other Side

16) On the Table Below:

- 1) Please circle the number of individuals in the patient's household.
- 2) Please circle the **patient's total annual household income** corresponding with the number of individuals in the **patient's** household.

For the purpose of this form, the term household is defined as you and spouse if legally married and dependent children; or you and dependent children; or if you are over 18, single with no children then household of 1.

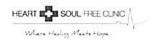
1	\$0 - \$17,150	\$17,151 - \$28,600	\$28,601 - \$45,750	More than \$45,750
2	\$0 - \$19,600	\$19,601 - \$32,650	\$32,651 - \$52,250	More than \$52,250
3	\$0 - \$22,050	\$22,051 - \$36,750	\$36,751 - \$58,800	More than \$58,800
4	\$0 - \$26,500	\$26,501 - \$40,800	\$40,801 - \$65,300	More than \$65,300
5	\$0 - \$31,040	\$31,041 - \$44,100	\$44,101 - \$70,550	More than \$70,550
6	\$0 - \$35,580	\$35,581 - \$47,350	\$47,351 - \$75,750	More than \$75,750
7	\$0 - \$40,120	\$40,121 - \$50,600	\$50,601 - \$81,000	More than \$81,000
8	\$0 - \$44,660	\$44,661 - \$53,900	\$53,901 - \$86,200	More than \$86,200

17) Number of persons in patient's hous	sehold:	ADULT(S)		_ CHILDRE	N
18) Does the patient reside in a single pa	arent ho	usehold?	YES		NO
If yes, is the single parent?	FEN	MALE	MALE	OTHER	
19) What does the patient identify as? Asian	Native	American or <i>i</i>	Δlaska Nati	We.	
Black or African American		Hawaiian or (Jtner Pacifi	c Islander	
Indian	White			(Other:
20) What is the patient's ethnicity?		Hispanic		Not Hispanic	
21) What is the patient's primary langua	ige (i.e. l	English, Spani	sh, Arabic,	Mandarin)? _	
22) Does the patient require an interpre	ter?	YES		NO	
23) Patient's Level of Education (Please 0	Circle On	ne)			
Current Student (Under 18 years old)		High School	Graduate/0	GED	Some College
Current Student (Over 18 years old)		Trade Schoo			College Graduate
Some School (No Diploma)					conege diaduate
Some School (No Diploma)		Other:			
24) Does the patient being seen receive a	any of th	ne following?	(Circle All T	hat Apply)	
Temporary Assistance to Needy Familie	s (TANF)	Qua	alified Med	icare Benefici	ary Food Stamps
Supplemental Security Income (SSI)	Pub	olic Housing	/Section 8	WIC	
Children's Health Insurance Program (Cl	HIP)	Me	dical Assist	ance	
25) How did the patient hear about Hear Friend Family Grace Car			5700 march 100	U C"'	. W. 1/5
Friend Family Grace Car Website Other Web		:	ree Clinic	Hope Clinic	C Work/Employer

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" resideaving blank will indicate a "No" response. Anemia	Patient Name:		Date	of Birth:
Anemia		Last		Month/Day/Year
AlDS/HIV Positive	ndicate which of the f	llowing you have had or	have at present. By checking the box	it will indicate a "Yes" response,
ANDS/HIV Positive Arthritis/Gout Arthritis/Gout Arthritis/Gout Arthritis/Gout Arthritis/Gout Arthritis/Gout Arthritis/Gout Arthritis/Gout Breathing Problems Broad Transfusion Breathing Problems Bruise Easily Convulsions Cortiso medica Disboetes Bload Transfusion Blisters Disorder Arthritis/Gout Anemia medica Disboetes Blisters Disorder Arthritis/Gout Anemia medica Disboetes Bruise Easily Winded Asthma Epileps Excessive Bledleng Drug Addiction Easily Winded Cancer Freque Frequent Headaches Excessive Thirst Fainting Spells/Dizziness Seizures Excessive Bledrat Heart Murmur Genital Herpes Genital Herpes Galaucoma Easily Winded E	eaving blank will indic	te a "No" response.		
Arthritis/Gout Blood Transfusion Blood Blood Blood Transfusion Cold Sores/Fever Congenital Heart Congenital Heart Anemia medica Diabetes Blisters Disorder Cancer Convulsions Cordision Blood Pressure Heat Murmur Genital Herpes Glaucoma Hepat Murmur Hepatitis Bor C Heart Pacemaker Heypoglycemia Herpes Low Blood Pressure Low Blood Pressure Lung Disease Parathyroid Disease Rheumatic Fever Rheumatic Fever Rheumatis Fever Sinus Trouble Bisters Sinus Trouble Bisters Spina Blfada Scalet Fever Sinus Trouble Bisters Spina Blfada Stomach/Intestinal Bisters Stomach/Intestinal Bisters Cordinal Herpes Cordinal Herpes Cordinal Heart Cordinal Heart Cordinal Heart Congenital Heart Cancer Cancer Cancer Convulsions Convulsions Convulsions Corbital Reart Aumania Method Heart Aumania Method Heart Aumania Method Heart Aumania Method Herpes Herpes Heart Trouble/Disease Rheumatic Fever Rheumatis Fever Rheumatis Fever Spina Blfada Stomach/Intestinal Scarlet Fever Store Herpes Coster Cerebral Infarction Growth tumors Obter Not Listed: Have you been hospitalized in the last five years due to surgery or illness? Describe below: Disease Taking medication for weight control (ie fen-phen) Has had complications following a dental treatment If checked any of the above, please explain: MEN: are you			□ Ane	emia 🗆 Angina
Artificial Heart Valve Blood Transfusion Breathing Problems Breathing Problems Blood Transfusion Cherno Blood Transfusion Chest Pains Condusions Control Convusions Chest Pains Chest Pains Cold Sores/Fever Congenital Heart Anemia medical Diabetes Blisters Disorder Anemia medical Condustry Congenital Heart Anemia medical Congenital Heart Congenital Heart Anemia medical Congenital Heart Congenital	AIDS/HIV Positive	Alzheimer's Disease	☐ Anaphylaxis ☐ Ast	hma 🗆 Blood disease
Blood Transfusion Breathing Problems Convulsions Cortiso Chest Pains Cold Sores/Fever Congenital Heart Anemia medication Diabetes Blisters Disorder Asthma Epileps Excessive Bleeding Drug Addiction Easily Winded Cancer Freque Frequent Headaches Excessive Thirst Fainting Spells/Dizziness Seizures Heart Heart Murmur Genital Herpes Heart Browle/Disease Emphysema Hepatit Hepatits Bor C Heart Pacemaker Heart Trouble/Disease Emphysema Hepatit Hepatits Bor C Heart Pacemaker Heart Browle/Disease Frequent Cough Hives or Hypoglycemia Herpes Helfest Book Pressure Heart Browle/Disease Frequent Cough Hives or Hypoglycemia Herpes Herpes Herpes Heypest Herpest Heypest Herpest Heypest Herpest Her		 Artificial Heart Valve 	☐ Artificial Joint ☐ Car	ncer
Chest Pains Diabates Bilsters Diabates Excessive Bleeding Excessive Bleeding Excessive Bleeding Frequent Headaches Excessive Bleeding Frequent Headaches Frequent Headaches Frequent Headaches Frequent Headaches Genital Herpes Genital Herpes Genital Herpes Glaucoma Hepattis B or C Heart Pacemaker Hepattis B or C Hepattis B or C Herpettis B or		 Breathing Problems 	☐ Bruise Easily ☐ Cor	nvulsions Cortisone
Excessive Bleeding		Cold Sores/Fever	□ Congenital Heart □ Ane	emia medication
Excessive Bleeding	Diabetes	Blisters	Disorder Ast	hma 🗆 Epilepsy or seizu
Frequent Headaches	Excessive Bleeding	 Drug Addiction 	□ Easily Winded □ Car	
Heart Murmur		 Excessive Thirst 	☐ Fainting Spells/Dizziness ☐ Sei	
Hepatitis B or C Heart Pacemaker Herpes Herpes High Blood Pressure Hay Freyer High Blood Pressure High Blo	100 0 m 100 100 100 100 100 100 100 100	☐ Genital Herpes	□ Glaucoma □ Em	Andrew region in the second se
Hypegycemia	Hepatitis B or C	 Heart Pacemaker 	☐ Heart Trouble/Disease ☐ Fre	A CONTRACTOR OF THE PROPERTY O
Low Blood Pressure Irregular Heartbeat Kidney Problems Hemophilia Jaw pal Parathyroid Disease Mitral Valve Prolapse High cholesterol Sickle c High cholesterol Sickle c	A Table		High Blood Pressure	어린 100 mm mm mm mm mm 기계
Parathyroid Disease Rheumatic Fever Sinus Trouble Thyroid Disease Venereal Disease Venereal Disease Preschiltis Presently being treated for any other illnesses Taking medication for weight control (ie fen-phen) Has had complications following a dental treatment Hecked any of the above, please explain: MEN: are you MEN: are			Vidnou Drobloms	
Rheumatic Fever Brychiatric Care Rematism Sinus Trouble Rheumatism Scarlet Fever Osteoprossis Ulcers Sinus Trouble Rheumatism Scarlet Fever Osteoprossis Ulcers Thyroid Disease Spina Bifada Disease Venereal Disease Venereal Disease Venereal Disease Venereal Disease Venereal Disease Vellow Jaundice Truberculosis Herpes Zoster Cerebral infarction Growth tumors ther Not Listed: ave you been hospitalized in the last five years due to surgery or illness? Describe below: Presently being treated for any other illnesses Currently under care of Cardiologist Use tobacco or previously used tobacco Presently taking medication designed to affect bone thinning (ie.Actenol) ARN: are you ARN: are you anant/Trying to get pregnant Yes No Nursing Yes No Taking oral contraceptives Yes No outling to any of the following? (circle all that apply): Acrylic Aspirin Codeine Latex Call Anesthetics Metal Penicilin Sulfa Drugs Other: By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of in my health as soon as possible.	Parathyroid Disease		Mitral Valve Prolance	전문에 발흥합니어 및 보이다
Scarter rever Thyroid Disease Spina Bifada Scaract/Intestinal Disease Venereal Disease Vene	Rheumatic Fever		Radiation Treatments	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Thyroid Disease Spina Bilada Disease Recent weight loss Herpes Zoster Gerebral infarction Growth tumors	Sinus Trouble	Rheumatism	Scarlet Fever	
Venereal Disease Tonsilitis Disease Herpes Zoster Herpes Zoster Cerebral infarction Growth tumors Herpes Zoster Cerebral infarction Herpes Zoster Cerebral i	Thyroid Disease	Spina Bifada	Stomach/Intestinal	
ther Not Listed: ave you been hospitalized in the last five years due to surgery or illness? Describe below: Presently being treated for any other illnesses Taking medication for weight control (ie fen-phen) Has had complications following a dental treatment I checked any of the above, please explain: DEN: are you DEN: are you DAEN: are you DAEN: are you DAILY rying to get pregnant Yes No Nursing Yes No Taking oral contraceptives Yes No Death and Penicilin Sulfa Drugs Details and Penicilin Su		□ Tonsilitis .	Disease	**************************************
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her Not Listed:				
Presently being treated for any other illnesses Taking medication for weight control (ie fen-phen) Has had complications following a dental treatment Tichecked any of the above, please explain: DEN: are you Jant/Trying to get pregnant Journally to get pregnant Journally to any of the following? (circle all that apply): Acrylic Aspirin Codeine Latex Cal Anesthetics Metal Penicilin Sulfa Drugs Other: Juse tobacco or previously used tobacco Presently taking medication designed to affect bone thinning (ie.Actenol) Aspirin Codeine Latex Codeine Latex Cal Anesthetics Metal Penicilin Sulfa Drugs Other: Juse controlled substances? (circle) Yes No If Yes: Junedications, supplements, and/or vitamins taken within the last two years: By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of in my health as soon as possible.			L GIO	will tulliors
nant/Trying to get pregnant Yes No Nursing Yes No Taking oral contraceptives Yes No ou allergic to any of the following? (circle all that apply): Acrylic Aspirin Codeine Latex ocal Anesthetics Metal Penicilin Sulfa Drugs Other: ou use controlled substances? (circle) Yes No If Yes: Il medications, supplements, and/or vitamins taken within the last two years: By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of in my health as soon as possible.	Taking medication for Has had complication	weight control (ie fen-phen) following a dental treatment	Use tobacco or prePresently taking me	viously used tobacco edication designed to affect
By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of in my health as soon as possible.	nant/Trying to get pregnant ou allergic to any of the fol ocal Anesthetics N	owing? (circle all that apply):	Acrylic Aspirin Coo Sulfa Drugs Other:	deine Latex
in my health as soon as possible.	ill medications, supplement	, and/or vitamins taken withi	n the last two years:	
in my health as soon as possible.				
ture of patient, parent, or guardian (responsible party)			rmation is correct and I understand it is my res	sponsibility to inform the office of any cha
and or patients, parents, or guardian (responsible party).	ture of patient, parent, or g	ardian (responsible party):		

Signature Date ____/___/____



HEART AND SOUL CLINIC, INC. 17338 Westfield Park Rd., Ste. 1 Westfield, IN 46074 RELEASE OF INFORMATION

For and in consideration of the medical treatment and/or consultation made available to me without charge at Heart and Soul Clinic, Inc., I hereby agree to the following terms:

- I hereby grant Heart and Soul Clinic, Inc. full and unrestricted access to all of my health records, regardless of their location and/or of whose custody the health records are currently in.
- I hereby release, relieve and discharge from liability Heart and Soul Clinic, Inc., its officers, directors, agents employees, and volunteers of and from all liability for any and all losses, injuries, or damages to either my person or to my property, occasioned by, in any manner growing out of, or as a direct or indirect result of my receipt of any diagnosis, consultation, procedures, medications, treatments or advise or by anyone providing any such diagnosis, consultation, procedures, medications, treatment or advise in which the Heart and Soul Clinic, Inc. has any responsibility or its made available by it.
- I hereby give my permission to the Heart and Soul Clinic, Inc. its agents and volunteers to treat me during this clinic visit and all subsequent visits and to provide drugs, medical care and other services and supplies as are needed for my health and well-being. I acknowledge that no representations, warranties or guarantees as to results or cures have been made to me by Heart and Soul Clinic, Inc., or its agents, nor have I relied upon any such representations, warranties or guarantees.
- I hereby give my permission for the Heart and Soul Clinic, Inc., to pursue other health professionals in consultation/referral regarding my medical condition for the purpose of continuity of health care. I am aware that the Heart and Soul Clinic, Inc., cannot guarantee the care provided by a referring physician or health care specialist will be rendered free of charge to me and that the Heart and Soul Clinic, Inc., cannot assume responsibility for payment.
- By my signature below, I certify that I have read this *Release of Information* (or have had the same read to me) and that I fully understand its provisions I now voluntarily sign the *Release* as evidence of my intent and agreement to be bound by it.

Printed Patient Name	Date
Patient Signature	
Patient Representative	Relationship

(OMB NO. 0915-0293) Revised June 18,2009

Appendix C FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Sample Patient Notice of Limited Liability of FTCA Deemed Volunteer Free Clinic Health Care Professionals

Notice to Patients

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as its practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(B), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by an free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (I.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997, may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

Acknowledged:	
(Patient Signature)	
(Patient name, printed legibly)	
Date	

Proposed Project: Free Clinic FTCA Deeming Application (OMB No. 0915-0293) Revision