

## HEART AND SOUL REGISTRATION FORM

(Please Print)

Today's date:

### PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date: (Mon/Day/Year) / /		Age: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street address:		Cell phone#: ( )	Home phone #: ( )		
P.O. box:	City:	State:	ZIP Code:		

### INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No

### AUTHORIZATION FOR MESSAGES

I authorize messages regarding my appointments be released via (check boxes):

- ☐ Text (SMS)
  - ☐ Phone number to receive texts: \_\_\_\_\_
- ☐ Voicemail
- ☐ E-mail
  - ☐ Please provide e-mail: \_\_\_\_\_
    - The Heart and Soul Clinic e-mail is a non-secure e-mail system

### IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )
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You may **release** medical information to the following:

\_\_\_\_\_  
Name Relationship Phone

\_\_\_\_\_  
Name Relationship Phone

The above information is true to the best of my knowledge.

\_\_\_\_\_  
Patient Signature (parent signature if patient is under 18 years old)

\_\_\_\_\_  
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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

Patient's Gender: FEMALE MALE OTHER: \_\_\_\_\_

Patient's Zip Code: \_\_\_\_\_

Patient's County: \_\_\_\_\_

1) In the last year, has the **patient** struggled to secure immediate and or affordable mental health care? YES NO

2) Is there an individual in the **patient's** household who is disabled or handicapped? YES NO

Is the **patient** being seen disabled? YES NO

3) Patient's marital status: MARRIED SINGLE WIDOW/WIDOWER

4) Does the **patient** work: FULL-TIME PART-TIME UNEMPLOYED DOES NOT APPLY

5) Does the **patient** struggle with transportation for things like receiving medical care and working? YES NO

6) Patient's current housing situation: RENT OWN DOES NOT HAVE HOUSING OTHER: \_\_\_\_\_

7) In the last 6 months, has the **patient** been unable to pay for or obtain food? YES NO

8) In the last 6 months, has the **patient** been unable to pay their utilities? YES NO DOES NOT APPLY

9) Has the **patient** being seen received assistance from their township 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

Does the **patient** vape? YES NO

If yes, would the **patient** like to receive a referral for the Indiana Smoking Cessation Program? YES NO

12) In the last 6 months, has the **patient** experienced any concerns with drugs or alcohol? YES NO

13) Does the **patient** being seen have medical insurance? YES NO

If yes, what type? (i.e Medicare, Medicaid, Employer): \_\_\_\_\_

14) Does the **patient** being seen have a Primary Care Physician? YES NO

15) Does the **patient** being seen have dental insurance? YES NO

If yes, what type? (i.e Medicare, Medicaid, Employer): \_\_\_\_\_

*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** household: ADULT(S) \_\_\_\_\_ CHILDREN \_\_\_\_\_

18) Does the **patient** reside in a single parent household? YES NO

If yes, is the single parent? FEMALE MALE OTHER

19) What does the patient identify as?

Asian Native American or Alaska Native  
 Black or African American Native Hawaiian or Other Pacific Islander  
 Indian White Other: \_\_\_\_\_

20) What is the patient's ethnicity? Hispanic Not Hispanic

21) What is the patient's primary language (i.e. English, Spanish, Arabic, Mandarin)? \_\_\_\_\_

22) Does the patient require an interpreter? YES NO

23) Patient's Level of Education (Please Circle One)

Current Student (Under 18 years old) High School Graduate/GED Some College  
 Current Student (Over 18 years old) Trade School College Graduate  
 Some School (No Diploma) Other: \_\_\_\_\_

24) Does the **patient** being seen receive any of the following? (Circle All That Apply)

Temporary Assistance to Needy Families (TANF) Qualified Medicare Beneficiary Food Stamps  
 Supplemental Security Income (SSI) Public Housing/Section 8 WIC  
 Children's Health Insurance Program (CHIP) Medical Assistance

25) How did the **patient** hear about Heart and Soul (Circle One)?

Friend Family Grace Care Center Trinity Free Clinic Hope Clinic Work/Employer  
 Website Other Web Other: \_\_\_\_\_



# Medical History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Month/Day/Year

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive   | <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Angina                 |
| <input type="checkbox"/> Arthritis/Gout      | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joint          | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blood disease          |
| <input type="checkbox"/> Blood Transfusion   | <input type="checkbox"/> Breathing Problems     | <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Chemotherapy           |
| <input type="checkbox"/> Chest Pains         | <input type="checkbox"/> Cold Sores/Fever       | <input type="checkbox"/> Congenital Heart          | <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Cortisone medication   |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Blisters               | <input type="checkbox"/> Disorder                  | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Epilepsy or seizures   |
| <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Drug Addiction         | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Frequent diarrhea      |
| <input type="checkbox"/> Frequent Headaches  | <input type="checkbox"/> Excessive Thirst       | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart attack / failure |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Genital Herpes         | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Hepatitis A            |
| <input type="checkbox"/> Hepatitis B or C    | <input type="checkbox"/> Heart Pacemaker        | <input type="checkbox"/> Heart Trouble/Disease     | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Hives or rash          |
| <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Herpes                 | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Frequent cough      | <input type="checkbox"/> Liver disease          |
| <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Kidney Problems           | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Jaw pain               |
| <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Mitral Valve Prolapse     | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Sickle cell anemia     |
| <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Radiation Treatments      | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Swelling of the limb   |
| <input type="checkbox"/> Sinus Trouble       | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Scarlet Fever             | <input type="checkbox"/> Leukemia            | <input type="checkbox"/> Ulcers                 |
| <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Spina Bifida           | <input type="checkbox"/> Stomach/Intestinal        | <input type="checkbox"/> Osteoporosis        |   |
| <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Tonsillitis            | <input type="checkbox"/> Disease                   | <input type="checkbox"/> Recent weight loss  |   |
|  | <input type="checkbox"/> Yellow Jaundice        | <input type="checkbox"/> Tuberculosis              | <input type="checkbox"/> Herpes Zoster       |   |
|  |   |  | <input type="checkbox"/> Cerebral infarction |   |
|  |   |  | <input type="checkbox"/> Growth tumors       |   |

Other Not Listed: \_\_\_\_\_

Have you been hospitalized in the last five years due to surgery or illness? Describe below:

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- |   |  |
|---|--|
| <input type="checkbox"/> Presently being treated for any other illnesses    | <input type="checkbox"/> Currently under care of Cardiologist                                      |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Use tobacco or previously used tobacco                                    |
| <input type="checkbox"/> Has had complications following a dental treatment | <input type="checkbox"/> Presently taking medication designed to affect bone thinning (ie.Actenol) |

If checked any of the above, please explain:

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**WOMEN:** are you...

Pregnant/Trying to get pregnant Yes No Nursing Yes No Taking oral contraceptives Yes No

Are you allergic to any of the following? (circle all that apply):

Acrylic Aspirin Codeine Latex

Local Anesthetics Metal Penicilin Sulfa Drugs Other: \_\_\_\_\_

Do you use controlled substances? (circle) Yes No If Yes: \_\_\_\_\_

List all medications, supplements, and/or vitamins taken within the last two years:

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- ☐ By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Signature of patient, parent, or guardian (responsible party): \_\_\_\_\_

Name and relationship to patient: \_\_\_\_\_

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

**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**