HEART SOUL FREE CLINIC

Where Healing Meets Hope

HEART AND SOUL REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ She/Her ☐ He/Him ☐ They/Them	Marital status (circle one) Single / Mar / Wid / Partner

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: (Mon/Day/Year) / /	Age:	Sex: ❑ Male ❑ 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, education, and special events 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 #: ( )

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

12/29/22

HEART SOUL FREE CLINIC

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Patient Demographic Information

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 PARTNER

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 or active military? YES NO

11) Does the **patient** smoke? YES NO

Does the **patient** vape? YES NO

Does the **patient** use tobacco products? 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 dental insurance? YES NO
If yes, what type? (i.e Medicare, Medicaid, Employer): _____

Please Turn Page to the Other Side

15) **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 - $19,200	$19,201 - $32,000	$32,001 - $51,200	More than $51,200
2	$0 - $21,950	$21,951 - $36,550	$36,551 - $58,480	More than $58,480
3	$0 - $24,700	$27,701 - $41,100	$41,101 - $65,760	More than $65,760
4	$0 - $27,750	$27,751 - $45,650	$45,651 - $73,040	More than $73,040
5	$0 - $32,470	$32,471 - $49,350	$49,351 - $78,960	More than $78,960
6	$0 - $37,190	$37,191 - $53,000	$53,001 - $84,800	More than $84,800
7	$0 - $41,910	$41,911 - $56,650	$56,651 - $90,640	More than $90,640
8	$0 - $46,630	$46,631 - $60,300	$60,301 - $96,480	More than $96,480

16) Number of persons in **patient's** household: ADULT(S) _____ CHILDREN _____

17) What does the patient identify as?

Asian | Native American or Alaska Native | Middle East
Black or African American | Native Hawaiian or Other Pacific Islander
Asian Indian | White | Other: _____

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

19) What is the patient's primary language (i.e. English, Spanish, Arabic, Mandarin)? _____

20) Does the patient require an interpreter? YES NO

21) **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: _____

22) 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

23) 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.

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

Other Not Listed: _____

Have 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
- ☐ Currently under care of Cardiologist
- ☐ Use tobacco or previously used tobacco
- ☐ Presently taking medication designed to affect bone thinning (ie.Actenol)

If checked any of the above, please explain:

_____

_____

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:

_____

_____

_____

☐ 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.

HIPAA - I acknowledge that I have received/been offered a copy of this office's *HIPAA Notice of Privacy Practices.*

_____ _____
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