New Patient Requirements

Please bring copies of the following documents to your appointment for eligibility purposes.

- Photo ID and Social Security Card
- Proof of Onslow County residency (i.e. A bill with name and address on it)
- Proof of income which includes 60 day paystubs and 1040 tax forms, unemployment, food stamp letter, Disability determination letter.
  - If Married we need spouses proof of income
  - If you are unemployed and someone else provides your financial assistance we need a letter of support with signature and date stating how they support you.
- Medicaid Denial Letter

Some documents may take longer to obtain.

- Food stamp letter (Dept. of Social Services)
- Disability Determination/eligibility letter
- Medicaid Denial Letter (Dept. of Social Services)
- Veterans Administration Benefits (if prior military)
Caring Community Clinic  
200-L Doctors Drive, Jacksonville, NC 28546  
Phone: 910-346-6149  •  Fax: 910-346-8342  
www.onslowco.org  
Patient Eligibility Form

Patient Information

Name: ____________________________________________  
Last: ___________________________________  
First: ___________________________________  
MI: ___________________________________

Home Phone #: ___________________________  
Cell Phone #: ___________________________  
Work Phone #: ___________________________

Street Address:  
Street: ___________________________  
City: ___________________________  
State: ____________  
Zip Code: ____________

Mailing Address:  
Street: ___________________________  
City: ___________________________  
State: ____________  
Zip Code: ____________

Date of Birth ___________________________  
Age: ___________________________  
Social Security #: ___________________________  
Sex: M [ ]  F [ ]

Marital Status: Married [ ]  Widowed [ ]  Divorced [ ]  Separated [ ]  Single [ ]  Living with significant Other [ ]

Race: Black [ ]  White [ ]  Native American [ ]  Hispanic [ ]  Other [ ]

Emergency Contact:  
Name: ____________________________________________  
Relationship: ________________________________________  
Phone: ____________________________________________

How did you hear about the Caring Community Clinic? ___________________________

Insurance Information

Veteran: Yes [ ]  No [ ]  Veterans Assistance?: Yes [ ]  No [ ]  Medicaid: Yes [ ]  No [ ]  Medicare: Yes [ ]  No [ ]

Is your deduction more than $5,000 a year: ___________________________

Other Insurance: Yes [ ]  No [ ]  Company Name: ____________________________  
Insurance Pays Meds: Yes [ ]  No [ ]  %

Employment Information- Patient

Employer: ____________________________________________  
Address: ____________________________________________  
Phone: ____________________________________________

Occupation: ____________________________________________  
How long: ___________________________  
Full or Part Time: ___________________________  
Hours per week: ___________________________

Wages $ _____/Hr _____  Weekly income: ___________________________  
Bi-weekly income: ___________________________  
Monthly Income: ___________________________

Secondary Employer: ____________________________________________  
Address: ____________________________________________  
Phone: ____________________________________________

Occupation: ____________________________________________  
How long: ___________________________  
Full or Part Time: ___________________________  
Hours per week: ___________________________

Wages $ _____/Hr _____  Weekly income: ___________________________  
Bi-weekly income: ___________________________  
Monthly Income: ___________________________

Employment Information-Spouse or significant other

Unemployed? Yes [ ]  No [ ]  Length of time: ___________________________  
Reason for unemployment: ___________________________

Employer: ____________________________________________  
Address: ____________________________________________  
Phone: ____________________________________________

Occupation: ____________________________________________  
How long: ___________________________  
Full or Part Time: ___________________________  
Hours per week: ___________________________

Wages $ _____/Hr _____  Weekly income: ___________________________  
Bi-weekly income: ___________________________  
Monthly Income: ___________________________

Secondary Employer: ____________________________________________  
Address: ____________________________________________  
Phone: ____________________________________________

Occupation: ____________________________________________  
How long: ___________________________  
Full or Part Time: ___________________________  
Hours per week: ___________________________

Wages $ _____/Hr _____  Weekly income: ___________________________  
Bi-weekly income: ___________________________  
Monthly Income: ___________________________

11
<table>
<thead>
<tr>
<th>Household Size</th>
<th>Number of Dependents</th>
<th>Under 18</th>
<th>Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONTHLY INCOME</td>
<td>PATIENT (PER MONTH)</td>
<td>SPOUSE (PER MONTH)</td>
<td></td>
</tr>
<tr>
<td>Employment Income</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Unemployment Income</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Food Stamps</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Social Security or Disability Income</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Retirement Income</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Receive Child Support? Yes □ NO □</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Amount per child $</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receive Alimony? Yes □ NO □</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>WIC (woman, infants, children)</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Receive any other income? Yes □ NO □</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>From Who?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Monthly Income</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>TOTAL GROSS HOUSEHOLD INCOME PER YEAR</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Zero Income
If no income: How long with no income? Why?

Who provides for your shelter, food, personal expenses?
(Please have person or organization who supports you write a letter of support)

Do you receive food stamps? Yes □ NO □ Amount $ ______

Assets / living situation
Rent. Own □ Other □ Describe
Other Real Estate? Yes □ NO □ If yes, Describe

Automobile: Paid Off □ Financed □ Make____ Year ______ Amt Owed $ ______
Automobile: Paid Off □ Financed □ Make____ Year ______ Amt Owed $ ______
Other Vehicles: [Boat, Motorcycle, etc.] Paid Off □ Financed □ Make____ Year ______ Amt Owed $ ______

Name of Bank/Credit Union

[ ] Checking Balance $ ______ [ ] Saving Balance $ ______

[ ] Certificate of Deposit Amount $ ______ [ ] Stocks/Bonds Value $ ______

Taxes
Did you file tax last year? Yes □ NO □
If yes, please provide copy of tax return you filed with IRS, even if financial situation has changed.

CERTIFICATE
I hereby affirm that, to the best of my knowledge and belief, the information provided in this application is true and complete. I understand and hereby authorize the Caring Community Clinic to make a complete investigation of all the statements made herein. I understand that if I obtain assistance by false representation, all funds advanced on my behalf will be due and payable. I will inform the Caring Community if my address, phone numbers, income or insurance status changes within 30 days of any change.

Patient signature ____________________________ Date __________

For office use:
Does patient meet eligibility guidelines? Yes □ NO □ Verified by ____________________________
Date
In effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age:</th>
<th>Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Presenting Problem:

<table>
<thead>
<tr>
<th>Patient’s Medical History</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Smoke</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
</tr>
<tr>
<td>Mental Disorder</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>Heart Problems</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
</tr>
<tr>
<td>Skin Problems</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>AIDS/HIV</td>
<td></td>
</tr>
<tr>
<td>Currently Pregnant</td>
<td></td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td></td>
</tr>
</tbody>
</table>

Are you currently being seen by any other Medical Provider?  □ YES  □ NO

Medications: Please list all medications you take and their dosages.

<table>
<thead>
<tr>
<th>Medications:</th>
<th>None</th>
<th>Dosage:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vitamins:

Herbal supplements:

<table>
<thead>
<tr>
<th>Allergies: Please list type and reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>None</th>
</tr>
</thead>
</table>

The above information is true and accurate.

Patient Signature:

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Letter of Support

I am providing support for __________________________ in the following fashion.

(Patient's Name)

Check only ONE of the three boxes below:
☐ Lives with me at the address below and receives free room and board.
☐ Lives with me and shares expenses. My contribution to expenses is indicated below.
☐ Does not live with me but I provide support as indicated below.

I provide cash and other funding in the approximate amount indicated below. Enter an approximate dollar amount for each item and check whether this amount is provided weekly or monthly. If you do not provide cash or other funding for a particular item, enter "$0".

<table>
<thead>
<tr>
<th>Item</th>
<th>$</th>
<th>Weekly</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Explain Below)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Print Name: ___________________________________________ Date: __________________________

Sign Name: ________________________________

Address: ____________________________________________
PATIENT CONTRACT AND RELEASE FORM

Patient’s Name ___________________________ Date of Birth ______________

By my signature I acknowledge and fully agree to the following matters:

1. I am requesting and desire to receive medical care at the Caring Community Clinic from one
   of the volunteer health care providers, physicians, physicians assistants, nurse practitioners or
   nurses who are part of the medical care staff of the caring community clinic.

2. I understand that all such health care at the Caring Community Clinic will be provided to me
   free of charge. However, if you are referred to a third party provider and charged a fee for their
   service, the Caring Community Clinic will not be held responsible for the charges but will assist
   in helping you resolving or reducing the charges. The final decision rests with that provider.

3. As an inducement and to encourage these health care providers to provide free medical care to
   me, and in consideration for receiving such medical services, I hereby release and hold harmless
   the caring community clinic and any health care provider who may provide medical services to
   me from liability and any injury I may receive as a result of the free medical services I may
   receive whether caused by inadvertence, neglect or accident.

4. I (the patient) am _______ years of age and I am either able to read this document, or I have
   had this document read to me by the witness/reader whose name appears below.

Patients Signature: ___________________________ Date: ______________

Staff Signature: ___________________________ Date: ______________
MEDICAL INFORMATION RELEASE FORM

Name: ____________________________ Date of Birth ____________

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to
and claims information. This information may be released to:

Name: ____________________________ Relation ____________ Number ____________

Name: ____________________________ Relation ____________ Number ____________

Information is not to be released to anyone.

This Release of information will remain in effect until terminated in writing.

MESSAGES

Please call: [ ] my home  [ ] my work  [ ] my cell  Number: ____________________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] email me at: ____________________________

The best time to reach me is on this day: ____________________________ TIME: ____________________________

__________________________ ____________________________
Patient Signature Date

__________________________ ____________________________
Staff Signature Date
Listed below are guidelines as a patient of The Caring Community Clinic you are asked to adhere to:

- If you receive any medical insurance while a patient it is your responsibility to notify the clinic immediately, failure to do so can result in dismissal without notification.
- If you have an address and/or phone change, please notify staff immediately.
- Patients are to arrive at the time given by staff for appointment check-in. Clinic will be closed for all federal holidays, inclement weather, and non-availability of essential staff. All patients will be notified and rescheduled accordingly.
- You must call the clinic and give 24 hour notice for appointment cancellations.
- If you are a "No Show" three times, you will be dis-enrolled from the clinic. Cancellations without 24 hour notice are considered, "No Shows".
- The clinic is not responsible for ensuring that you have medication to cover this time frame due to noncompliance.
- Patients’ are required to be follow up in the clinic every 90-180 days from his or her last appointment or he or she will be subject to disenrollment.
- There is ZERO tolerance allowed for disrespecting or demonstrating disruptive behavior towards staff and volunteers. Upon first occurrence, you may or may not receive a warning of dismissal by the Clinical Director. However, the second occurrence will be an immediate dismissal.
- Medications WILL NOT be dispensed unless a doctor or Pharmacist is in the clinic.
- If you are unable to pick up your medications on the scheduled date and time then you are to list any individual(s) on the information sheet provided and make sure the individual picking up your medications has a valid ID with them at the time of pick-up.
- Providing false information is grounds for immediate dismissal.
- You will be notified of your recertification date at the time of your initial intake. It is your responsibility to present the clinic with the required documents prior to your recertification date, failure to recertify on time will result in refusal of services and eventually dismissal from the clinic due to non-compliance.

Patient Signature________________________________________ Date ______________

Staff Signature________________________________________ Copy given to pt? ___ yes ___ no
Caring Community Clinic
Scheduling and Attendance Policy

Effective January 1, 2019

Due to the high volume of patients cared for at the Caring Community Clinic and the limited availability of our volunteer physicians, nurse practitioners, and physician assistants, the scheduling and attendance policy has been carefully reviewed, analyzed and updated to best meet the needs of our patients, while respecting the invaluable time donated by our volunteers.

Please carefully read and initial next to each of the following changes. By doing so you are acknowledging that you have received the updated policy and agree to the terms and conditions listed below. Please direct any questions or concerns to the Caring Community Clinic staff immediately, before signing, to prevent any confusion and to help the clinic run more efficiently.

1. Patients will be scheduled for follow-up appointments during check-out. If a schedule is not available for when the patient needs an appointment the patient will be placed on a waitlist. Once the schedule becomes available, the patient will be CALLED by our staff to schedule the appointment.

2. Patients WILL NOT be scheduled for appointments unless the patient VERBALLY agrees to the time and date of the appointment.

3. Patients needing an appointment that have not been seen by a provider and are not on a waitlist will be able to do so by calling the clinic on Mondays between 8:00 AM and 5:00 PM. Appointments will be given on a first-come, first-served basis until all appointments for that week ONLY have been filled.

4. Should a patient call after Monday and/or there are no appointments left for that week, they will be instructed to call back on the following Monday to request an appointment.

5. If you cannot make it to your appointment, we require that you give a 24-hour notice to cancel/reschedule your appointment. If you do not come to your appointment AND do not call, you will automatically be considered a “NO SHOW.”

6. If you are a “NO SHOW” three times, you will be dis-enrolled from the clinic. Cancellations without a 24-hour notice are considered “NO SHOW,” unless under extenuating circumstances.

7. Exceptions may be extended for requests to cancel/reschedule appointments with less than 24-hour notice for certain extenuating circumstances. Extenuating circumstances in which less than 24-hour notice is forgivable includes: emergencies (for self or family), no transportation, cannot get time off from work. CCC staff will make sure to document on the communication log when the patient cancelled the appointment and the reason for the cancellation. EXCEPTIONS WILL BE GRANTED ON A CASE-BY-CASE BASIS.

8. Should a patient accumulate three (3) consecutive forgiven “NO SHOWS,” the patient will be placed on probation for 6 months. Should the patient have any other NO SHOW during that probationary period, the Director will review the patient’s chart and determine if the patient should remain eligible for care or if the patient should be dis-enrolled.

Printed Name: ____________________________ Date: ____________________________

Signature: ____________________________ Phone Number: ____________________________
PRIVACY POLICY

The Caring Community Clinic is committed to protecting your privacy. As a healthcare provider, we know your trust in us is of central importance. This policy discloses our information use policies and practice in detail. Please read it to learn more about the ways we protect the information we collect, and to find out how you can limit the information about you that is shared. If the Caring Community Clinic changes any information practices, we will provide you notice of any material changes.

Strict Security Measures

Caring Community Clinic takes the security of information very seriously and has established security standards and procedures to prevent unauthorized access to patient information. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard patient information.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive.

We may use or disclose identifiable health information about you without your authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law such as for law enforcement in specific circumstances. In any other situation we will ask for your written authorization to disclose information. You can later revoke that authorization to stop any further uses or disclosures.

We may change our policies at any time. Before we make a significant change in our policies we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment payment and administrative purposes except when specifically authorized by you, when required by law or in emergencies. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access or correction to your records, you may contact the person listed below. You may also send a written complaint to the US Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you decide to contact the undersigned person with a complaint, or if you send a written complaint to the US Department of Health and Human Services, you will not suffer any retaliation.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice of our information practices, and follow the information practices that are described in this notice.
If you have questions or complaints, please contact:

Clinic Director
200 Doctors Drive STE L
Jacksonville, NC 28546
(910)346-6149

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the main health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I’ve provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon.

I fully understand and accept the terms of this consent.

________________________________________  ________________________________
Patient Name                                      Date

________________________________________  ________________________________
Staff Signature                                   Date
Medical Records Release Consent

Print Name: ___________________________ SS#: ___________________________

Date of Birth: ___/___/____

I authorize the release of my medical health information from

Name of Facility: ___________________________

Address: __________________________________________

Phone Number: ______________________ Fax Number: ______________________

to The Caring Community Clinic.

☐ Progress Note ☐ Labs/Xrays ☐ All ☐ Other (Please Describe): ___________________________

Please list dates of service to be released: __________________________

I give my voluntary consent for the above medical information to be released. I understand that this consent is
valid until the request is fulfilled or until I give written notice to revoke this consent.

__________________________________________ Date

Patient Signature

__________________________________________ Date

Staff Signature

PLEASE FAX RECORDS TO: (910) 346-8342
THIRD PARTY PRESCRIPTION PICK UP AUTHORIZATION

I ________________________________, understand that prescriptions are to be picked up on the Wednesday following my refill request between the hours of 2:30 pm and 3:30 pm ONLY. In the event that I am unable to pick up my prescription(s) myself, please allow the individuals listed below to pick up my prescription(s) for me. If I wish to change this list at any time, I will notify the Caring Community Clinic in writing of my desire to do so.

People authorized to pick up my prescriptions are:

1. ___________________________ Phone: ___________________________

2. ___________________________ Phone: ___________________________

3. ___________________________ Phone: ___________________________

My signature below verifies that I have read, understood and agreed to the above.

Patient’s signature ___________________________ Date ___________________________
FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

INSERT CLINIC NAME and ADDRESS

Patient Notice of Limited Liability for FTCA Deemed Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Independent Contractors 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 is 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 any free clinic volunteer health care practitioner, board member, officer, employee, or independent contractor 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, board member, officer, employee, or independent contractor 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), (e)). 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