

Patient Name:	MRN#:
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We are excited for the opportunity to help meet your healthcare needs.

NEW PATIENT PACKETS CAN BE SUBMITTED ON TUESDAYS FROM 9AM-11AM OR THURSDAYS FROM 3PM-5PM.

To accept and begin review of your application, this packet must include:

<input type="checkbox"/>	VALID PHOTO ID May include a copy, or present ID to clinic front desk staff who will be happy to copy for you.
<input type="checkbox"/>	RECENT UTILITY BILL For proof of residence in our service area, if utility bill not in your name, provide an alternate bill or piece of mail addressed to you at your current physical address.
<input type="checkbox"/>	PROOF OF HOUSEHOLD INCOME Most recent year's TAX RETURN for ALL MEMBERS of your household who earn financially. Any AWARD LETTERS OR CARDS that support your current state of financial need. Examples include: social security, unemployment, housing or food assistance benefits (SNAP card), child or spousal support, workers' comp, disability, etc. *Please note: In order to provide our patients with free or low-cost referrals to specialists, lab, and imaging services which are required for primary care, we partner with outside organizations such as the Health Alliance for the Uninsured (HAU). Because these agencies REQUIRE us to provide patients' proof of income, we must have this information up to date and on file for all current patients. If you do not have the specific forms listed above, please call the clinic and request to speak with someone regarding proof of income requirements for potential new patients. Note: If you DO NOT have last year's tax return, you will need to provide updated financial information at EVERY appointment as requested.
<input type="checkbox"/>	COMPLETED APPLICATION PACKET PAPERWORK Registration form, Health History, Patient Rights and Responsibilities, Information/Privacy Acknowledgement, Consent for Services

If you need help completing your packet, or have questions about the application process, please contact the clinic directly at (405)749-0800.

Packet accepted by:	Date:
Financial Document review by:	Date:
Nurse Review by:	Date:
<input type="checkbox"/> APPROVED/ Appt Date & Time:	<input type="checkbox"/> DENIED/ Reason:
Date:	Note:

Patient
Initials

Crossings Clinic is unable to treat emergency conditions or Workman's Comp injuries and cannot establish social security disability or assist patients with court cases related to their medical condition. The clinic does not have the resources to determine a patient's ability or inability to perform any type of work.

Dear Potential New Patient,

We are so blessed that you're considering Crossings Community Clinic to serve your medical needs. We look forward to addressing your health concerns, and in order to qualify as a patient you will need to meet the following guidelines:

1. Have no medical or dental insurance
2. Be between the ages of 18 and 64 (Medical Only)
3. Live in one of the following zip codes: 73114, 73120, 73132, 73162
4. Have proof of income and living at or below 200% of the Federal Poverty Guidelines

Note: Spanish speaking only patients are responsible for bringing an interpreter who is 18 years or older.

If you believe you meet these requirements, please complete our new patient application and provide us with a **utility bill, recent tax return and a photo ID**. We will then confirm your eligibility and if approved, contact you to schedule a new patient appointment.

Our goal is to help you during this time when you have no access to healthcare and no means to pay for private care. We hope to partner with you in a holistic approach to your overall wellness, to include your physical, emotional, and spiritual health. As a patient of Crossings Community Clinic, you will be provided limited medical, dental, and vision care at no charge, limited medication allocation and/or written prescriptions to be filled by your local pharmacy. We encourage our patients to participate in recovery, nutrition, diabetic education, and fitness classes for your benefit at no cost. As your financial situation improves, we will offer services to assist you in the process of obtaining private insurance or reduced fee medical care at clinics with a full range of services.

We believe God directed you our way to serve you the best way we can. If we are unable to serve your medical needs at our clinic, we will provide you a resource list of other low cost or charitable clinics in the area.

Most of all, please know that you are loved by God and He truly cares for you.

Blessings,

Crossings Community Clinic

"...Love your neighbor as yourself."

Mark 12:30-31



10255 NORTH PENNSYLVANIA AVE
 OKLAHOMA CITY, OK 73120
 405.749.0800

PATIENT INFORMATION

Full Legal Name: (last, first, middle)			Date of Birth:		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married <input type="checkbox"/> Partnered	Age:	Social Security Number: - -		
What is your race? (Check all that apply.) <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Other			What is your ethnicity? <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		
US Citizen? (clinic purposes only) <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
Current Home Address: (Include city, state, zip)				Homeless? Circle: YES / NO	
Home Phone Number: () -		Cell Phone Number: () -		Email Address	

EMERGENCY CONTACTS

Name:	Name:
Relationship:	Relationship:
Phone:	Phone:
OK to share medical information? YES / NO	OK to share medical information? YES / NO

INSURANCE COVERAGE AND ELIBILITY

ARE YOU ELEGIBLE FOR OR COVERED BY:	YES	NO	APPLIED	PENDING	DENIED
MEDICARE (Age 65+)					
MEDICAID/SOONERCARE (Low income state provided)					
INDIAN HEALTH SERVICES (CDIB card)					
PRIVATE INSURANCE(marketplace or employer-offered)					
VETERANS HEALTH BENEFITS					

HOUSEHOLD FINANCIAL INFORMATION

How many adults (18+) live in your home?	How many children (under 18)?
How many people in the home have an income of any kind? (including unemployment, disability, SSI, retirement income)	
Total amount that YOU earn for the household? \$ _____ <input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> monthly <input type="checkbox"/> yearly	
COMBINED income earned by ALL members of the household? \$ _____ <input type="checkbox"/> weekly <input type="checkbox"/> biweekly y <input type="checkbox"/> monthly <input type="checkbox"/> yearly	DID YOU FILE TAXES FOR LAST YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE

ADDITIONAL INFORMATION

Have you been seen as a patient of Crossings Community Clinic before? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Health Concern(s):		
VISION care needs? <input type="checkbox"/> YES <input type="checkbox"/> NO	DENTAL care needs? <input type="checkbox"/> YES <input type="checkbox"/> NO	How long have you been without medical insurance? Last doctor who cared for you regularly?
Preferred Pharmacy:		



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HEALTH HISTORY – PATIENT ESTABLISHING CARE:

MEDICATIONS (including herbals, birth control, and over-the-counter meds)					<input type="checkbox"/> None
	Name	Dose	Taking	Not Taking	Need Refills
1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT AND PAST MEDICAL PROBLEMS (check all that apply)			<input type="checkbox"/> None
<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Cancer or Leukemia	<input type="checkbox"/> Hemophilia	
<input type="checkbox"/> Thoughts of harming yourself or others	<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema, COPD, Chronic Bronchitis	<input type="checkbox"/> HIV positive or AIDS	
<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Enlarged Heart or CHF	<input type="checkbox"/> Heart Pacemaker or Defibrillator	
<input type="checkbox"/> Currently Nursing	<input type="checkbox"/> Epilepsy, Seizures, Convulsions	<input type="checkbox"/> Kidney Dialysis	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Headaches or Migraines	<input type="checkbox"/> Schizophrenia / Bipolar	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack or Chest Pain	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Allergies or Hay Fever	<input type="checkbox"/> Heart Valve Defect or Surgery	<input type="checkbox"/> Sickle Cell Disease or Trait	
<input type="checkbox"/> Artificial joint or bone replacement	<input type="checkbox"/> Heart Bypass, Angioplasty, Stents	<input type="checkbox"/> Transplanted Organ	
<input type="checkbox"/> Blood clots, DVT, Pulmonary Embolism	<input type="checkbox"/> Heart Murmur		
<input type="checkbox"/> Bone, muscle or joint disorder			
Other: _____			

ALLERGIES		<input type="checkbox"/> None
Food allergies: _____	Are you allergic to Iodine or shellfish? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Medication allergies: _____	Are you allergic to Latex or rubber? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SURGERIES		<input type="checkbox"/> None
Month / Year	Type of Surgery	

HOSPITALIZATIONS / ER VISITS		<input type="checkbox"/> None
Month / Year	Reason for hospital stay / ER Visit	

FAMILY HISTORY (check all that apply)									<input type="checkbox"/> None / Unknown
Family Member	Still Living?	Diabetes	High Blood Pressure	Heart Disease	Cancer	Asthma	Birth Defect	Mental Illness	Substance Abuse
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

TOBACCO USE / SMOKING					
Are you currently a smoker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use other forms of tobacco? (check all that apply)	<input type="checkbox"/> pipe	<input type="checkbox"/> snuff
	<input type="checkbox"/> Former Smoker			<input type="checkbox"/> cigars	<input type="checkbox"/> chew
Do you smoke every day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many years have you smoked?		
How many packs of cigarettes per day?	<input type="checkbox"/> less than half a pack		How long since you <u>last</u> smoked?	<input type="checkbox"/> < 1 month	<input type="checkbox"/> 1-5 years
	<input type="checkbox"/> 1 pack			<input type="checkbox"/> 3-6 months	<input type="checkbox"/> 6-10 years
	<input type="checkbox"/> more than 1 pack			<input type="checkbox"/> 7-12 months	<input type="checkbox"/> > 10 years
Are you:	<input type="checkbox"/> Ready to quit	<input type="checkbox"/> Thinking about quitting	<input type="checkbox"/> Not ready to quit		

ALCOHOL USE		
Did you have a drink containing alcohol in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, how often did you drink?	<input type="checkbox"/> monthly or less	<input type="checkbox"/> 2-4 times per month
	<input type="checkbox"/> 2-3 times per week	<input type="checkbox"/> 4+ times per week
How many drinks did you have on a typical day when you were drinking in the past year?		
How often do you have 6 or more drinks on one occasion?		

SUBSTANCE USE			
Have you used any non-medical drugs in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, which drug(s) (including marijuana):	Are you still using?		<input type="checkbox"/> Yes
			<input type="checkbox"/> No
How many months ago did you last use?	<input type="checkbox"/> <6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> 12-24 months
	<input type="checkbox"/> 24+ months		

SEXUAL HISTORY						
Are you sexually active?	<input type="checkbox"/> Yes, within the last month			Do you have any history of sexually transmitted infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes, in the past					
	<input type="checkbox"/> Never been sexually active					
Do you have sex with?	<input type="checkbox"/> Men		<input type="checkbox"/> Both	If yes, which infections?	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Herpes
	<input type="checkbox"/> Women				<input type="checkbox"/> Neither	<input type="checkbox"/> Gonorrhea
				<input type="checkbox"/> HPV	<input type="checkbox"/> Trichomonas	
				<input type="checkbox"/> HIV	<input type="checkbox"/> _____	
Do you use birth control/protection?						

WOMENS HEALTH HISTORY
Do you have periods? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IRREGULAR
Last well woman exam (month/year): Last mammogram (month/year): Any breast changes/lumps?:
History of women's health concerns: (History of STD or pelvic infection/ infertility/ fibroids or cysts/ abnormal pap/ HPV/) <input type="checkbox"/> YES <input type="checkbox"/> NO Explain: _
Obstetric History:
Total number of pregnancies in your life: Total number of early losses (including early miscarriage or abortion): Total number of full-term births: Total number of premature births: Number of living children:

MENS HEALTH HISTORY
History of testicular trauma or surgery: <input type="checkbox"/> YES <input type="checkbox"/> NO
History of men's health concerns: (STD/STI / testicular pain or swelling/ penile pain or discharge / visible sores/ sexual difficulties) <input type="checkbox"/> YES <input type="checkbox"/> NO
Year of last prostate/rectal exam:
Prostate Concerns:
Any trouble urinating or emptying bladder? <input type="checkbox"/> YES <input type="checkbox"/> NO Waking at night to urinate? <input type="checkbox"/> YES <input type="checkbox"/> NO Blood in urine? <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney/urine/prostate infection? <input type="checkbox"/> YES <input type="checkbox"/> NO Testicular pain or swelling with straining/lifting/ or coughing? <input type="checkbox"/> YES <input type="checkbox"/> NO

OTHER			
As a child, did you complete the recommended vaccination series?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Have you ever had any of the following illnesses? <input type="checkbox"/> YES (check all that apply) <input type="checkbox"/> NO	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Shingles <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic Fever		
Have you had any of the following vaccines as an adult? <input type="checkbox"/> YES (check all that apply & write year) <input type="checkbox"/> NO	<input type="checkbox"/> Tetanus/Tdap/dTap _____ <input type="checkbox"/> Flu vaccine _____ <input type="checkbox"/> Pneumonia vaccine _____ <input type="checkbox"/> Other _____		
Do you have concerns about your diet? <input type="checkbox"/> YES <input type="checkbox"/> NO Explain:			
Have you ever had a colonoscopy <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, year:			

DEMOGRAPHIC INFORMATION	
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married <input type="checkbox"/> Partnered
Spouse Name:	Number of Children:
What is the highest level of school you have completed?	<input type="checkbox"/> Elementary School <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate School
What is the highest degree you earned?	<input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Vocational certification <input type="checkbox"/> Associate's degree (junior college) <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctorate

Health starts where we work, play, learn, eat, and sleep. Problems in any of these areas can affect your health. We may be able to provide assistance, so we hope you will answer the following questions. You do not have to answer any questions you do not want to. Anything you write will be kept confidential in your medical record.

PLEASE CHECK THE BOX FOR YOUR ANSWERS.

Which best describes your current occupation?

- Homemaker, not working outside the home
- Employed (or self-employed) full time
- Employed (or self-employed) part time
- Employed, but on leave for health reasons
- Employed but temporarily away from my job (other than health reasons)
- Unemployed or laid off 6 months or less
- Unemployed for more than 1 year

What is your housing situation today?

- I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, or in a park)
- I have housing today, but I am worried about losing housing in the future
- I have housing

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- Yes
- No
- Already shut off

**Think about the place you live. Do you have problems with any of the following?
(Check all that apply)**

- Bug infestation
- Mold
- Lead paint or pipes
- Inadequate heat
- Oven or stove not working
- No or not working smoke detectors
- Water leaks
- None of the above

How confident are you filling out forms by yourself?

- Not at all
- Somewhat
- Extremely

**How confident are you that you can control and manage most of your health problems?
(Select a number from 1 to 10.**

1 = not at all confident 10 = very confident)

1 2 3 4 5 6 7 8 9 10
Not at all Very Confident

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- Not hard at all
- Not very hard
- Somewhat hard
- Hard
- Very hard

Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Never true
- Sometimes true
- Often true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- Never true
- Sometimes true
- Often true

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

- Yes
- No

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?

- Yes
- No

Do you feel stress—tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time—these days?

- Not at all
- Only a little
- To some extent
- Rather much
- Very much

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

- Never
- Once a week
- Twice a week
- Three times a week
- More than three times

How often do you get together with friends or relatives?

- Never
- Once a week
- Twice a week
- Three times a week
- More than three times

How often do you attend church or religious services?

- Never
- 1 to 4 times per year
- More than 4 times per year

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?

- Yes
- No

Within the last year, have you been afraid of your partner or ex-partner?

- Yes
- No

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?

- Yes
- No

Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?

- Yes
- No

Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

- Yes
- No

PATIENT RIGHTS AND RESPONSIBILITIES

Name: <i>(Last, First, M.I.)</i>	DOB:
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At Crossings Community Clinic, we believe in team-based health care. This means that we, as health care providers have an active role, and you, as a patient have an active role.

Crossings Community Clinic is responsible for:

- Providing evidence-based primary care services.
- Providing considerate and respectful care.
- Explaining all procedures and test results at patient appointments.
- Doing our best to respond to all calls and messages within 24 hours during weekdays.
- Keeping all medical information private.

You, as a patient, are responsible for:

- _____ Being on time for appointments. If you need to cancel or reschedule, you must call us at (405) 749-0800 at least 24 hours prior to the appointment time. Leaving a voicemail is acceptable. If you miss three (3) appointments in one year without calling, Crossings Community Clinic may discontinue care.
- _____ Obtaining any lab testing or imaging that is ordered by your physician prior to your next appointment.
- _____ Informing Crossings Community Clinic within 30 days of any changes in your insurance status, income, or contact information. Failure to do so may result in delayed treatment.
- _____ Timely providing updated household financial information each year.
- _____ Being an active partner in managing your health.
- _____ ***Spanish speaking only patients are responsible for bringing an interpreter who is 18 years or older to all appointments.***

***Please initial each line to acknowledge that you have read your responsibilities as a patient at Crossings Community Clinic and agree to comply.

Patient information:

- **Medications:** Crossings Community Clinic does not prescribe or dispense any narcotics or controlled substances. Please notify us 10 days before you run out of a medication. We will not be able to fill walk in medication requests.
- **Courtesy:** Crossings Community Clinic will not tolerate inappropriate/abusive language, behavior and/or treatment directed toward providers/staff/volunteers by patients and/or their representatives. The clinic reserves the right to refuse treatment.
- **Limitations:** Crossings Community Clinic is limited in the services which can be provided to patients and cannot guarantee access to specialty referrals and imaging. **The clinic is unable to treat emergency conditions or Workman's Comp injuries and cannot establish social security disability or assist patients with court cases related to their medical condition.** The clinic does not have the resources to determine a patient's ability or inability to perform any type of work.

I HAVE READ AND UNDERSTAND THIS PATIENT RIGHTS AND RESPONSIBILITIES DOCUMENT AND AGREE TO COMPLY WITH ALL OF ITS TERMS AND CONDITIONS.

Patient/Guardian Signature: _____ Date: _____



10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

PATIENT INFORMATION AUTHORIZATION AND PRIVACY ACKNOWLEDGMENT

Name: <i>(Last, First, M.I.)</i>	DOB:
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AUTHORIZATION TO CONVEY PERSONAL HEALTH INFORMATION BY MESSAGE

I authorize Crossings Community Clinic staff, providers, and volunteers to leave messages for me at phone numbers I have provided to them as personal contact information. I understand that these messages could include Protected Health Information (PHI) pertaining to my appointment dates/times, care, and treatment and may come in the form of voicemail or text message.

I AUTHORIZE CROSSINGS COMMUNITY CLINIC TO LEAVE MESSAGES CONTAINING PROTECTED HEALTH INFORMATION:
Select all that apply: <input type="checkbox"/> By Voicemail <input type="checkbox"/> Via Text Message <input type="checkbox"/> With Family/Friends <input type="checkbox"/> No Messages Please

AUTHORIZATION TO SHARE PERSONAL HEALTH INFORMATION

I give permission for Crossings Community Clinic to provide my Protected Health Information to the following people:

NAME	RELATIONSHIP	PHONE NUMBER

I acknowledge and understand that this authorization will be kept as part of my medical record and will remain in effect until revoked by me in writing. It is my responsibility to inform Crossings Community Clinic should I wish to change any of my contact information.

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the opportunity to review the Crossings Community Clinic’s Notice of Privacy Practices and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient/Guardian signature *Date*

CONSENT FOR SERVICES

Name: <i>(Last, First, M.I.)</i>	DOB:
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**PLEASE READ THIS FORM CAREFULLY,
AS IT CONTAINS IMPORTANT INFORMATION PERTAINING TO YOUR CARE.**

My signature below signifies that I understand the following:

- Medical services offered through Crossings Community Clinic may be administered by a variety of licensed medical professionals.
- Non-medical services may be provided by a variety of non-licensed professionals, counselors or other clinicians, which may include students or interns.
- To ensure continuity of care, it may be necessary for Crossings Community Clinic’s care providers (physicians, counselors, dentists, etc.) to share information about you with other providers involved in your care.

**VOLUNTEER MEDICAL PROFESSIONAL SERVICES IMMUNITY ACT
STATEMENT OF DISCLOSURE AND ACKNOWLEDGEMENT**

Oklahoma Law provides that certain medical professionals are **immune from liability in a civil action** based on the acts or omissions of those professionals in providing volunteer medical professional services. The law covers physicians, physician’s assistants, registered nurses, advanced nurse practitioners, vocational nurses, pharmacists, podiatrists, dentists, dental hygienists or assistants, medical assistants, occupational or physical therapists, psychologists, and optometrists if:

1. The volunteer medical services were provided at a free clinic where neither the professional(s) nor the clinic receives any kind of compensation for any treatment provided at the clinic;
2. The professional(s) were engaged in active practice or if retired, were still eligible to provide medical professional services within the state.
3. The professional(s) were acting in good faith and, if licensed, the services provided were within the scope of the licenses of the professional(s);
4. The professional(s) committed the act or omission in the course of providing professional services;
5. The damage or injury was not caused by gross negligence or willful and wanton misconduct by the professional(s).

I understand that based upon provisions 1-5 above from the Volunteer Professional Services Immunity Act, that I am giving up my right to recover for injuries or damages in a lawsuit against any volunteer professional(s), health practitioner, or the Crossings Community Clinic in exchange for receiving free professional medical services.

I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of any procedures and/or treatments performed. I acknowledge that even though my Provider will seek to advise me of known risks involved with any treatments and/or procedures performed, additional unforeseeable and/or unpreventable situations could arise in the course of my care, which might result in injury.

I have read and understand the above consent form in its entirety. Any questions have been answered to my satisfaction in a language that I understand. Understanding the above, I hereby give my consent to receive services from Crossings Community Clinic. My consent is valid until I withdraw it.

Patient/Guardian signature: _____ Date: _____

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- PATIENT COPY**
- ___ Being on time for appointments. If you need to cancel or reschedule, you must call us at (405) 749-0800 at least 24 hours prior to the appointment time.
 - ___ Leaving a voicemail is acceptable. If you miss three (3) appointments in one year without calling, Crossings Community Clinic may discontinue care.
 - ___ Obtaining any lab testing or imaging that is ordered by your physician prior to your next appointment.
 - ___ Informing Crossings Community Clinic within 30 days of any changes in your insurance status, income, or contact information. Failure to do so may result in delayed treatment.
 - ___ Timely providing updated household financial information each year.
 - ___ Being an active partner in managing your health.
 - ___ **Spanish speaking only patients are responsible for bringing an interpreter who is 18 years or older to all appointments.**

Patient information:

- **Medications:** Crossings Community Clinic does not prescribe or dispense any narcotics or controlled substances. Please notify us 10 days before you run out of a medication. We will not be able to fill walk in medication requests.
- **Courtesy:** Crossings Community Clinic will not tolerate inappropriate/abusive language, behavior and/or treatment directed toward providers/staff/volunteers by patients and/or their representatives. The clinic reserves the right to refuse treatment.
- **Limitations:** Crossings Community Clinic is limited in the services which can be provided to patients and cannot guarantee access to specialty referrals and imaging. **The clinic is unable to treat emergency conditions or Workman's Comp injuries and cannot establish social security disability or assist patients with court cases related to their medical condition.** The clinic does not have the resources to determine a patient's ability or inability to perform any type of work.

I HAVE READ AND UNDERSTAND THIS PATIENT RIGHTS AND RESPONSIBILITIES DOCUMENT AND AGREE TO COMPLY WITH ALL OF ITS TERMS AND CONDITIONS.

PATIENT COPY