| Patient Name: | MRN#: |
| --- | --- |
| Medical ◻︎ | Dental ◻︎ |

We are excited for the opportunity to help meet your healthcare needs.

To accept and begin review of your application, the requirements are:

| 1.) ◻︎ | **Are you currently being seen at a different clinic or a different doctor? Yes** ◻︎ **No** ◻︎ |
| --- | --- |
| 2.) ◻︎ | **NO FORMS OF INSURANCE** |
| 3.) ◻︎ | **VALID PHOTO ID (Driver’s License, Passport, or ID)** |
| May include a copy or present ID to clinic front desk staff who will be happy to make a copy |
| 4.) ◻︎ | **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. |
| 5.) ◻︎ | **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: Pay stubs for the last 60 days, W2, employer letter with number of hours and pay rate, 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.  **If you are eligible for Medicaid but received a denial, a copy of your denial letter is required.**  **Note:** If you **DO NOT** have last year’s tax return, you will need to **provide updated financial information at EVERY appointment as requested.** |
| 6.) ◻︎ | **COMPLETED APPLICATION PACKET WITH #3, #4, and #5** |
| Registration form, Health History, Patient Rights and Responsibilities, Information/Privacy Acknowledgement, Consent for Services |

| Packet accepted by: | | | Date: |
| --- | --- | --- | --- |
| Financial Document review by: | | | Date: |
| Nurse Review by: | | | Date: |
|  APPROVED/**Appt Date & Time:** | |  DENIED/ Reason: | |
| Date: | Note: | | |
|  |  | | |

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 Oklahoma County
4. Have proof of income for the past 60 days and living at or below 300% 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**

| **PATIENT INFORMATION** | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Full Legal Name:  (last, first, middle) | | | | | | | | Date of Birth: | | |
| Sex   Male  Female | Marital Status:   Single  Married  Widowed  Divorced  Separated   Never Married  Partnered | | | | Age: | | Social Security Number:    - - | | | |
| What is your race? (Check all that apply.)   Asian  Native Hawaiian   Other Pacific Islander  Black/African American   American Indian/Alaska Native  White  Other | | | | | | What is your ethnicity?   Hispanic/Latino   Not Hispanic/Latino | | | | |
| US Citizen? (clinic purposes only)   Yes  No | | | Primary Language Spoken:   English  Spanish  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Current Home Address:  (Include city, state, zip) | | | | | | | | | | Homeless?  Circle: YES / NO |
| Home Phone Number:  ( ) - | | Cell Phone Number:  ( ) - | | | | | | | Email Address | |
| **EMERGENCY CONTACTS** | | | | | | | | | | |
| Name:  Relationship:  Phone:  OK to share medical information? YES / NO | | | | Name:  Relationship:  Phone:  OK to share medical information? YES / NO | | | | | | |

| **INSURANCE COVERAGE AND ELIGIBILITY** | | | | | |
| --- | --- | --- | --- | --- | --- |
| ARE YOU ELIGIBLE 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? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_  weekly  biweekly  monthly  yearly | | |
| COMBINED income earned by ALL members of the household?  $\_\_\_\_\_\_\_\_\_\_\_\_\_  weekly  biweekly  monthly  yearly | | DID YOU FILE TAXES FOR LAST YEAR?   YES  NO  UNSURE |
| Are you employed?  Yes- full time Yes- part time No | | Employer Name: |

| **ADDITIONAL INFORMATION** | | |
| --- | --- | --- |
| Have you been seen as a patient of Crossings Community Clinic before?  Yes  No | | |
| Primary Health Concern(s): | | |
| VISION care needs?   YES  NO | DENTAL care needs?   YES  NO | How long have you been without medical insurance? |
| Last doctor who cared for you regularly? |
| Preferred Pharmacy: | | |

HEALTH HISTORY – PATIENT ESTABLISHING CARE:

| **MEDICATIONS (including herbals, birth control, and over-the-counter meds)**  **None** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  | Name | Dose | Taking | Not Taking | Need Refills |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
| 8 |  |  |  |  |  |
| 9 |  |  |  |  |  |
| 10 |  |  |  |  |  |
| 11 |  |  |  |  |  |
| 12 |  |  |  |  |  |
| 13 |  |  |  |  |  |
| 14 |  |  |  |  |  |
| 15 |  |  |  |  |  |

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

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ALLERGIES**  **None** | |
| --- | --- |
| Food allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Are you allergic to Iodine or shellfish?  YES  NO |
| Medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Are you allergic to Latex or rubber?  YES  NO |

| **SURGERIES**  **None** | |  | **HOSPITALIZATIONS / ER VISITS**  **None** | |
| --- | --- | --- | --- | --- |
| **Month / Year** | **Type of Surgery** |  | **Month / Year** | **Reason for hospital stay / ER Visit** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

| **FAMILY HISTORY (check all that apply)**  **None / Unknown** | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Member** | Still Living? | Diabetes | High Blood Pressure | Heart Disease | Cancer | Asthma | Birth Defect | Mental Illness | Substance Abuse |
| **Father** |  |  |  |  |  |  |  |  |  |
| **Mother** |  |  |  |  |  |  |  |  |  |
| **Sibling- Sister/Brother** |  |  |  |  |  |  |  |  |  |
| **Mother’s Mother** |  |  |  |  |  |  |  |  |  |
| **Mother’s Father** |  |  |  |  |  |  |  |  |  |
| **Father’s Mother** |  |  |  |  |  |  |  |  |  |
| **Father’s Father** |  |  |  |  |  |  |  |  |  |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

| **ALCOHOL USE** | | | |
| --- | --- | --- | --- |
| Do you drink alcohol? | |  Yes |  No |
| If yes, how often do you drink? |  monthly or less  2-4 times per month  2-3 times per week  4+ times per week | | |
| How many drinks containing alcohol do you have on a typical day when you are drinking?  1 or 2  3 or 4  5 or 6   7 or 9  10 or more | | | |
| How often do you have 6 or more drinks on one occasion?  never  Less than monthly  Monthly  Weekly   Daily or almost daily | | | |

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

| **SEXUAL HISTORY** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Are you sexually active? |  Yes, within the last month   Yes, in the past   Never been sexually active | |  | Do you have any history of sexually transmitted infections? | |  Yes | |  No |
| Do you have sex with? |  Men   Women |  Both   Neither |  | If yes, which infections? |  Chlamydia   Gonorrhea   HPV   HIV | |  Herpes   Syphilis   Trichomonas   \_\_\_\_\_\_\_\_\_ | |
| Do you use birth control/protection? | | | | | | | | |

| **WOMENS HEALTH HISTORY** |  | **MENS HEALTH HISTORY** |
| --- | --- | --- |
| Do you have periods?  YES  NO   IRREGULAR |  | History of testicular trauma or surgery:  YES  NO |
| Last well woman exam (month/year):  Last mammogram (month/year):  Any breast changes/lumps?: |  | History of men’s health concerns: (STD/STI / testicular pain or swelling/ penile pain or discharge / visible sores/ sexual difficulties)  YES  NO |
| History of women’s health concerns: (History of STD or pelvic infection/ infertility/ fibroids or cysts/ abnormal pap/ HPV/)  YES  NO Explain:\_ |  | Year of last prostate/rectal exam: |
| 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: |  | Prostate Concerns:  Any trouble urinating or emptying bladder? YES NO  Waking at night to urinate?  YES  NO  Blood in urine?  YES  NO  Kidney/urine/prostate infection?  YES  NO  Testicular pain or swelling with straining/lifting/ or coughing?  YES  NO |

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

| **DEMOGRAPHIC INFORMATION** | | |
| --- | --- | --- |
| Marital Status: |  Single  Married  Widowed  Divorced  Separated  Never Married  Partnered | |
| Spouse Name: | | Number of Children: |
| What is the highest level of school you have completed? | |  Elementary School  High School  College  Graduate School |
| What is the highest degree you earned? |  High School Diploma  GED  Vocational certification  Associate’s degree (junior college)   Bachelor’s degree  Master’s degree  Doctorate | |

**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.

**SDOH (SOCIAL DETERMINANTS OF HEALTH)**

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.**

**Occupation**

**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

**Housing Stability**

**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

**In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?**

* Yes
* No

**In the last 12 months, how many places have you lived? (*Put the number in the box*)**



**In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (*including now*).**

* Yes
* No

**Financial Resource Strain**

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

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

**Food Insecurity**

**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

**Transportation Needs**

**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

**Physical Activity**

**On average, how many days per week do you engage in moderate to strenuous exercise (Like a brisk walk)? (Put the days in the box)**



**On average, how many minutes do you engage in exercise at this level? (Put the minutes in the box)**



**Stress**

**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

**Social Connections**

**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

**How often do you attend meetings of the clubs or organizations you belong to?**

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

**Are you married, widowed, divorced, separated, never married, or living with a partner?**

* Married
* Widowed
* Divorced
* Separated
* Never married
* Living with partner

**Intimate Partner Violence**

**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

**Depression**

**Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?**

* Not at all
* Several days
* More than half the days
* Nearly every day

**Over the past 2 weeks, how often have you felt down, depressed, or hopeless?**

* Not at all
* Several days
* More than half the days

**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

* Nearly every day

**PATIENT RIGHTS AND RESPONSIBILITIES**

| **Name:** *(Last, First, M.I.)* | **DOB:** |
| --- | --- |

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.***

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION AUTHORIZATION AND PRIVACY ACKNOWLEDGEMENT**

| **Name:** *(Last, First, M.I.)* |  | **DOB:** |
| --- | --- | --- |

| **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: ◻ By Voicemail ◻ Via Text Message ◻ With Family/Friends ◻ 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.



**CONSENT FOR SERVICES**

| **Name:** *(Last, First, M.I.)* |  | **DOB:** |
| --- | --- | --- |

|  | **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT RIGHTS AND RESPONSIBILITIES**

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.***

**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.**

