Revised 4/28/2015 **Name________________________**

Crescent Community Clinic
Application for Healthcare Services

Adults, ages 18 to 64 with no health insurance and limited income you **may be** eligible for free healthcare at the Crescent Community Clinic if you have a chronic health condition, been diagnosed with a mental health issue or have a dental problem. Please review eligibility criteria before completing the application.

NOTE: Our resources are limited. The clinic is not able to provide emergency medicine, orthopedic, obstetrics, surgery, ophthalmology, and vascular surgery, STD, HIV/AIDS or Hepatitis. We do not provide controlled medications.

Patients taking narcotics, opiates, methadone or being treated for pain management will not be eligible for services.

NOTE: Have you or do you plan on applying for disability? **Yes____ No____ ***Read our policy on disability**
When did you apply? **___________________________** Were you referred to the clinic by an attorney? **Yes___ No ___**

Disability Policy

Clinic is here to treat your chronic health condition only.
Clinic does not assist patients to apply for disability.
Clinic does not send patient records to attorneys – You must request your records and pick them up

Smoking Policy

NOTE: Do you smoke or use tobacco? Yes ___No ____ How much do you use tobacco products ______________

***If yes, you must attend the smoking cessation class before a medical appointment will be provided**
'Tools to Quit' smoking cessation program is offered monthly at no cost to you

Agreement

As a patient I agree to notify the clinic at least 24 hours prior to an appointment.
I understand that I will be disqualified from receiving services for the following reasons:

1. Non-compliance with following the medical instructions provided to me, including attending health literacy programs on diabetes, smoking cessation, nutrition and other health issues
2. Failure to notify the clinic when my financial status changes or failure to update my financial information yearly which will result in being ineligible for services
3. Missed appointment without notifying the office. Message may be left on answering machine at 352-610-9916 when office is closed
4. Abuse of the clinic services for disability claims
5. Disrespecting staff
6. If under the influence of alcohol or illicit drugs you will be dismissed from the clinic.
7. Failure to attend 'Tools to Quit' smoking cessation program within a reasonable period of time

I understand and will comply with the policy of the Crescent Community Clinic.

Signature ____ Date _____________________

Revised 4/28/2015

Crescent Community Clinic
Application

Please complete all information. Incomplete applications will delay approval for services.

Name ____________________________________ Date of Birth __/___/____/ Place of Birth______________

Address _________________________________ City__________________________ Zip ________________
*****Must be a Hernando County Resident and between ages 18 and 64 to be eligible for services**

Telephone _______________ Cell ________________ Email Address __________________________________

Single ___ Married___ Divorced ___ Primary Language ___________________ Education _________________

Social Security Number ______ _____ _____ Emergency Contact __________________ Phone _____________

Pharmacy ____________________________ Location ____

Signature of applicant ____________________________________ Date ___________________
You will be required to provide a copy of your Social Security card and photo identification at time of interview

I have read and understand the application and policy

Signature of patient ____ Date _________________

Access to healthcare is limited to: MUST CIRCLE YOUR HEALTH CONDITION(S)

Chronic Health
Asthma COPD Cancer Diabetes Epilepsy Heart Disease Hypertension Obesity Urology

Basic Dental
Oral Infection(s) Tooth Extraction(s) Fillings

Mental Health
Diagnosed mental illness Limited Counseling

NOTE: Sign and mail application to: 5244 Commercial Way, Spring Hill, FL 34606.

<u>**Do not fax**</u> application.

Intake specialist will schedule you for an appointment to finalize the application. You must include proof of income. It may be either a W-2 form, previous or current year's copy of the first page only of tax return, Social Security income letter/statement, or letter from person supporting you. You must meet the federal poverty guidelines to be eligible for services. In order to ensure that you will be eligible for Prescription Assistance Program (free medications) please go to healthcare.gov and apply for Affordable Care Act (Obama Care). If you meet federal poverty guidelines you will not qualify for ACA and will receive a letter which may be used for PPA

Revised 4/28/2015 **Name________________________**

Patient Medical Data

Are you under a physician's care now? ___ Yes ___ No Are you pregnant? ____ Yes ____ No

Current physician's name ____________________________________ Phone ______________________

Address ____ Fax _________________________

List your medical conditions and include the medications you are currently taking and past medications

Medical Condition	Medications
_________________________________	____
_________________________________	____
_________________________________	____
_________________________________	____

Do you have or had any of the following conditions?

Yes No
( ) ( ) Diabetes
( ) ( ) Epilepsy
( ) ( ) Heart Disease Heart Disorder
( ) ( ) High or Low Blood Pressure
( ) ( ) Obesity
( ) ( ) Asthma
( ) ( ) Urology
( ) ( ) Emphysema/COPD
( ) ( ) Cancer
( ) ( ) Pulmonology
( ) ( ) Hypertension
( ) ( ) Heart Disease
( ) ( ) Anxiety *
( ) ( ) Depression *
( ) ( ) Diagnosed Mental Illness

Yes No
( ) ( ) Heart Murmur
( ) ( ) Joint Replacement
( ) ( ) Valve Replacement
( ) ( ) Artery Stent
( ) ( ) Excessive or Prolonged Bleeding
( ) ( ) Anemia
( ) ( ) Aneurysm
( ) ( ) Hepatitis
( ) ( ) Rheumatic Fever
( ) ( ) Arthritis
( ) ( ) Lactose Intolerant
( ) ( ) Pacemaker
( ) ( ) Liver Disease
( ) ( ) Taking Osteoporosis medication
( ) ( ) Positive for HIV AIDS

*need further screening (limited counseling services)

List any drug allergies you may have

____

If you answered yes to any medical condition above, please explain

____

____

Date _______________ Patient Signature____

PLEASE READ CAREFULLY

Name_______________________

I hereby give my expressed consent for all present and future services, treatment and medications prescribed or provided to me by the Crescent Community Clinic volunteer professional staff.

I understand that certain procedures, treatment and other activities may be carried out by person(s) other than a licensed physician but such activities will be under the supervision and direction of a licensed physician.

In consideration of said present services and future services, treatment and medication received from the Crescent Community Clinic and without any other representation, promise or agreement oral or written, I hereby fully and completely release and discharge the said Crescent Community Clinic and all parties in interest from claims, demand, grievances and causer of action of every kind and nature whatsoever, including but without limitation of the foregoing, all liability for damages or injuries of every kind, nature description, known or unknown, permanent or otherwise, mow existing or which may hereafter arise from or out of the above mentioned services, treatment or medications received at the Crescent Community Clinic in the State of Florida.

I hereby authorize any licensed physician, medical practitioner hospital, clinic or any other medical or medically-related facility, medical information bureau or other organization or person that has any record or knowledge of me or of my health, to give Crescent Community Clinic any such information. I also authorize Crescent Community Clinic to dispense medical information to the aforementioned person, facilities and organization.

I have read and understand this consent and release.

Signature of patient_________________________________ Date __________________

Witnessed by Clinic volunteer staff ________________________________ Date ________________

Date _____________________________

Revised 4/28/2015 **Name______________________**

CRESCENT COMMUNITY CLINIC
5244 Commercial Way, Spring Hill, FL 34606
Phone: 352-610-9916 Fax: 352-610-9915

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________________ Date of Birth: ____________________________

Previous Name: ____________________________ Social Security #: ___________________________

I request and authorize ____
to release healthcare information for the patient named above to:

Crescent Community Clinic
5244 Commercial Way, Spring Hill, FL 34606
Fax 352-610-9915 Phone 352-610-9916

This request and authorization applies to:

[ ] Healthcare information relating to the following treatment, condition, or dates: _________________
____

[ ] All healthcare information

[ ] Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia non-specific urethritis, syphilis, VDRL, Immunodeficiency Syndrome, and gonorrhea.

___ Yes ___ No I authorize the release of my STD results, HIV/IDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these tests results to anyone.

___ Yes ___ No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient Signature ____________________________________ Consent and Release