Patient Name______________________________

Crescent Community Clinic Date of Birth_______________________________

Application for Healthcare Services Chart ID _____________________________________

Adults, ages 18 to 64 withouthealth insurance and limited income **may be** eligible for free healthcare at the Crescent Community Clinic. YouMUST have a **chronic health condition, been diagnosed with a mental health issue or have a dental need.** Please review eligibilitycriteria before completing the application.

NOTE: Our resources are limited. The clinic is **not able to provide emergency medicine, orthopedic, obstetrics, surgery, ophthalmology,vascular surgery or treatment for infectious diseases.**We do not provide controlled medications or birth control medication.**Patients taking narcotics, opiates, methadone or being treated for pain management will not be eligible for services.**

Disability Policy

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

Have you or do you plan on applying for disability? **Yes____ No____** When did you apply? **______________________**

Did an attorney refer you to the clinic? **Yes___ No ___** Attorney name**_______________________________________**

Smoking Policy

Do you smoke or use tobacco? Yes ____ No ____ How many cigarettes do you smoke DAILY? __________________

If you use tobacco products, you must attend a smoking cessation class before an appointment will be provided to you. 'Tools to Quit' smoking cessation free program is offered monthly at 10 am to noon. No late entryallowed.

Patient agrees to the following policies andunderstands that they will be disqualified from receiving services for any of the following reasons:

Non-compliance with following the medical instructions provided, including attending health literacy programs on diabetes, smoking cessation, nutrition and other health issues, and/or failure to attend 'Tools to Quit' smoking cessation program within allowable time frame.

1. 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
2. Missed appointment without notifying the office within 24 hours of appointment. Message may be left on answering machine at 352-610-9916(extension 1)when office is closed
3. Disrespecting staff
4. If under the influence of alcohol or illicit drugs at time of appointment you will be dismissed from the clinic
5. Missed lab testing, lost lab voucher or script
6. Failure to pick up diagnostic test voucher within 5 business days of issue with result in loss of voucher
7. Failure to pick up Form 1032 for referral to partnering provider within 5 business days will result in loss of voucher and appointment with provider. Form 1032 must be completed and brought to provider or you will have to pay for the appointment

I understand and will comply with the all policies of Crescent Community Clinic

Signature ____ Date ______________________________

Crescent Community Clinic
Patient Application

Please complete all information. Incomplete applications will delay approval for services.
******You must be a Hernando County Resident and between ages 18 and 64 to be eligible for services**
******If you received inpatient or emergency room services at the hospital(s) you <u>may be redirected elsewhere for services. Clinic is limited to chronic health care, palliative dental and mental health services.</u>**

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

Address _________________________________ City________________________________ Zip ________________

Telephone _______________ Cell ________________ Email Address _______________________________________

Single ___ Married___ Divorced ___ Primary Language ___________________ Education _____________________

Social Security Number ______ _____ _____ Driver's License Number _____________________________________

Emergency Contact ______________________________ Phone ____

Pharmacy ____________________________ Location ____________________Phone ________________________

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

Access to healthcare is limited to:<u>CIRCLE YOUR HEALTH CONDITION(S)</u>
Chronic Health
Asthma Arthritis COPD Cancer Diabetes Epilepsy Heart Disease Obesity Urology Women's Health

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

Mental Health
Diagnosed mental illness Limited Counseling Medication Management

An Intake Specialist will schedule you for an appointment to finalize the application. You must provide 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 you will receive a denial letter which may be used for PPA. You <u>MUST SUBMIT A MEDICAID DENIAL LETTER WITH THIS APPLICATION</u>

If you anticipate needing free prescriptions through the Pharmaceutical Prescription Assistance Program (PPA) you must have a denial letter from Medicaid. Having this letter on file will speed up requests for free medication.

I have read and completed the application to the best of my ability I understand thedisability and smoking policies. Sign and mail application to: 5244 Commercial Way, Spring Hill, FL 34606. **<u>Do not fax</u>** application.

Signature of patient ____ Date _________________

Patient Name________________________________
Patient Date of Birth ___________________________
Patient Chart ID _________________________________

Patient Medical History

Are you under a physician's care now? Yes ___ No___

Current physician's name __________________________________ Date last seen ________________________

Are you pregnant? Yes ____ No ___ Date of last period: ____

Phone _____________________ Fax _____________________ Email _________________________________

Address ___________________________________City_____________________ State_______Zip _______

Current Medications(including over-the-counter)

____

____

Do you have or had any of the following conditions?

Yes No	Yes No
( ) ( ) Diabetes	( ) ( ) Heart Murmur
( ) ( ) Epilepsy	( ) ( ) Joint Replacement
( ) ( ) Heart Disease Heart Disorder	( ) ( ) Valve Replacement
( ) ( ) High or Low Blood Pressure	( ) ( ) Artery Stent
( ) ( )Obesity	( ) ( ) Excessive or Prolonged Bleeding
( ) ( )Asthma	( ) ( ) Anemia
( ) ( )Urology	( ) ( ) Aneurysm
( ) ( )Emphysema/COPD	( ) ( ) Hepatitis
( ) ( ) Cancer	( ) ( ) Rheumatic Fever
( ) ( ) Pulmonology	( ) ( ) Arthritis
( ) ( ) Hypertension	( ) ( ) Lactose Intolerant
( ) ( ) Heart Disease	( ) ( ) Pacemaker
( ) ( ) Anxiety *	( ) ( ) Liver Disease
( ) ( ) Depression *	( ) ( ) Taking Osteoporosis medication
( ) ( ) Diagnosed Mental Illness*	( ) ( ) Positive for HIV AIDS

*(need further screening (limited counseling services)

ALLERGIES:____

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

____

Patient Signature____________________________________ **Date**___________________________________

Patient Name ________________________________
Date of Birth_________________________________
Patient Chart ID ______________________________

Consent for Treatment

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, now 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.

I also understand that I must re-certify each year to continue to be eligible for services.

Signature of patient____Date _________________________

Crescent Community Clinic does not receive federal or state funding and depends on donations to continue to provide services. Please budget your resources to donate at time of appointment. Thank you

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(s): ____

Social Security #: _____________________________ Driver's License Number _________________________________

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

Address where patient records are available ____

____

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 ____ Date _____________________________
Application revised 4/17/2017