Last_____ First_____ Middle_____

Date of Birth _____ Sex Assigned at Birth Male / Female

Applicant's Race (select all that apply):	Applicant's Ethnicity (Select One):
American Indian or Alaska Native	Asian
Asian	Hispanic / Latino
Black or African American	Black
Hispanic or Latino	Two or More Races
Native Hawaiian or Other Pacific Islander	American Indian / Alaskan Native
White	Native Hawaiian / Pacific islander
Other	White / Caucasian
	Other

Emergency Contacts:

Name:_____

Phone:_____

Name:_____

Phone:_____

Social Security or ITN:

_____

Primary Language: _____

Do you require an Interpreter: Yes / No

Email Address: _____

Mobile Phone: _____

Home Phone: _____

Address: _____

City: _____ **Zip:** _____ **County:** _____

Employer:_____ **Work phone:**_____

Highest Education:	What is your relationship status?
I did not graduate high school	Single / Student
High School	Married / Partner
Some College	Student
Associate Degree	Divorced / Separated
Bachelor's Degree	Widow

Do you currently serve, or have you ever served in the U.S. Military? Yes / No

How did you hear about us? Friend, Family, Coworker, Employer, Newspaper Ad, TV, Other

What is your Primary Reason for needing to be seen at Community Care Center today?

_____

Patient Consent (READ CAREFULLY)

I understand that Community Care Center ("CCC") may not be able to meet all of my health care needs. Doctors are available at CCC only during clinic hours. No providers are on call other hours. I know I must seek care somewhere else in an emergency or for care that cannot wait until clinic is open. I give my permission to be examined and treated by clinic doctors. I understand that students and other non-licensed healthcare providers may be assisting the providers. I understand that some services could be cancelled or need to be rescheduled without advance notice. I understand that clinic staff may need to reach me by telephone or mail for medical reasons. I consent to the use and disclosure of my protected health information for treatment purposes. When a referral is made for care outside of CCC, I understand that these services may not be free. I understand that CCC will make a referral on my behalf to HealthCare Access or another source of their choosing. I also understand that it is my responsibility to follow-up with a provider at Community Care Center in a timely manner if I have not heard from anyone about my referral. CCC has no control over the scheduling of care in other facilities. If the wait seems excessive, I understand that I have the option to request a copy of my referral form and choose another provider/facility of my choice that may or may not charge me.

I further understand that I must meet eligibility requirements of CCC to be a patient. I understand that if I provide false or incomplete information or fail to update my information, I may be terminated as a patient. I understand that it is my responsibility to advise staff if my family income increases or anyone in the family becomes eligible for or receives health insurance, Medicare, Medicaid, or VA benefits. Please note that by signing below you acknowledge that rude or abusive conduct toward staff or volunteers may be reason for termination as a patient of Community Care Center for Forsyth, Inc.

_____ _____

Patients Signature **Today's Date**

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Sample 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), (o)).

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

Community Care Center
No-Show Policy

Definition of a "No-Show" Appointment

A "no-show" appointment is any scheduled appointment for which the patient either

- Does not arrive for the appointment
- Cancels the appointment with less than 2 hours' notice
- Arrives more than 15 minutes late, whether or not they can be seen

Impact of a "No-Show" Appointment

"No-Show" appointments have a negative impact on our practice and our patients. When a patient is a "no-show", it jeopardizes the health of the "no-showing" patient and is unfair to other patients who could have taken the appointment.

How to Avoid Being a "No-Show" Patient

Avoid being a "no-show" patient by

- Confirming your appointment
- Arriving on time
- Giving at least 2 hours' notice to cancel / reschedule

Appointment Reminder

When time allows, we will attempt to contact you by telephone prior to your scheduled appointment to remind you of your visit. Please remember to inform our staff of any changes to your telephone number(s). **We encourage you to sign up for Novant Health's MyChart mobile app; this will keep you updated on your health and appointment times. If you are interested, please ask the front desk for a code to access the app.**

Consequences of "No-Show" Appointments

First Time:	Patient will receive a postcard notifying him/her of the missed appointment.
Second Time:	Patient will receive a letter along with a copy of the "No-Show" policy.
Third Time:	A patient missing a third appointment within a 12 month period will be suspended from the clinic for 6 months.

I have read and understand the "No-Show" Policy of the Community Care Center.

_____ _____

Patient Signature Date

Form 64 02-28-2022 Updated