COMMUNITY CARE CENTER

REGISTRATION FORM

PERSONAL INFORMATION

LAST NAME(S) :

FIRST NAME :

Date of Birth : _____ / _____ / _____ **Gender** : Male Female

Address : _____

Phone Number : _____ **E-Mail** : _____

Preferred Language : _____ **Social Security/ITIN Number** : _____

Interpreter Required? : Yes No **Civil Status** : Single Married Divorce Other

Race/Ethnicity : White Black/African American Asian Hispanic /Latino American Indian / Alaska Native Native Hawaiian / Pacific Islander

Highest Level of Education : Less than high school High school Some college (Associates) College (Bachelors and beyond)

Do you currently, or have you ever served in the US Armed Forces? : Yes No

Occupation : _____

Employer : _____ **Employer Phone Number** : _____

Reason for visit : _____

EMERGENCY CONTACT DETAILS

Contact Name : _____ **mobile Number** : _____

Contact Name : _____ **Mobile Number** : _____

How did you hear about us? : Friends/Family Employer/Coworkers Ad/TV Other

More Information :

2135 New Walkertown Rd,
Winston-Salem, NC, 27101

+1 336-723-7904

carectr.org

THANK YOU

_____

Signature

Missed Appointment Policy

DEFINITION OF A MISSED APPOINTMENT

A MISSED APPOINTMENT IS ANY SCHEDULED APPOINTMENT FOR WHICH THE PATIENT EITHER:

- ✦ DOES NOT ARRIVE TO THE APPOINTMENT
- ✦ CANCELS THE APPOINTMENT WITH LESS THAN 2 HOURS' NOTICE
- ✦ ARRIVES MORE THAN 15 MINUTES LATE, WHETHER OR NOT THEY CAN BE SEEN BY MEDICAL STAFF

IMPACT OF A MISSED APPOINTMENT

- MISSED APPOINTMENTS HAVE A NEGATIVE IMPACT ON OUR PRACTICE AND PATIENTS. WHEN A PATIENT MISSES AN APPOINTMENT, IT JEOPARDIZES THE HEALTH OF THE PATIENT WHO MISSED THE APPOINTMENT AND IS UNFAIR TO OTHER PATIENTS WHO COULD HAVE TAKEN THE APPOINTMENT.

HOW TO AVOID MISSING AN APPOINTMENT

- CONFIRM YOUR APPOINTMENT
- ARRIVE ON TIME
- GIVE AT LEAST 2 HOURS NOTICE BEFORE CANCELING/RESCHEDULING
- SIGN UP FOR NOVANT HEALTH'S MYCHART MOBILE APP TO KEEP UPDATED ON YOUR HEALTH AND APPOINTMENT TIMES
- HAVE PHONE NUMBER UP TO DATE AS THE CLINIC WILL ATTEMPT TO CONTACT YOU BY PHONE PRIOR TO THE APPOINTMENT

CONSEQUENCES OF MISSED APPOINTMENTS

- FIRST TIME: PATIENT RECEIVES A POSTCARD NOTIFYING THEM OF THE MISSED APPOINTMENT
- SECOND TIME: PATIENT RECIEVES A LETTER ALONG WITH A COPY OF THE MISSED APPOITNTMENT POLICY
- THIRD TIME: PATIENT WILL BE SUSPENDED FROM CLINIC FOR 6 MONTHS, IF 3RD APPOITNMENT IS MISSED WITHIN A 12 MONTH PERIOD

I HAVE READ AND UNDERSTOOD THE MISSED APPOINTMENT POLICY:

Signature **Date**

Patient Consent Form

I understand that the Community Care Center ("CCC") may not be able to meet all of my health care needs. Doctors are available at the 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 the 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 eligibltiy 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 family income increases or anyone in the family becomes eligible for or receives health insurance, Medicare, 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.

Signature

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