Intake Form

DEO CLINIC
VOLUNTEERS FOR HEALING

Last Name:_____First Name: _____Middle Initial:_____

Birth Date:_____ Gender:_____ County of Residence:_____

Address:_____

Email: _____Cell phone:_____Text? Yes No

Other Phone:_____

Circle marital status: married separated divorced widowed

Circle Ethnicity: Hispanic Non-Hispanic Preferred Language:_____

Circle Race: White African American Alaska Native American Indian Asian

Native Hawaiian/Pacific Islander Other:_____

Circle Highest education: primary secondary H.S./GED Bachelor's Degree Masters Doctorate

Housing: Rent Own Live with family/friend Shelter Homeless

Circle all that apply: Part-Time Temporary Agency Full-time Retired Seasonal
Full-Time Disabled Unemployed Employer:_____

Monthly Income:$_____Verification: pay stub tax return employer note

Did you file income tax last year: Yes No Have you applied for disability? Yes No

Insurance: None Military/VA Medicaid Commercial Dental Co-op/Other
MedIcare PART A PART B PART C PART D

Number in your household:_____ Financial dependents:_____

Household incomes:_____

How did you hear about DEO? Friend Hamilton Medical Healthcare Provider Internet

Print/Media Physician, Church or Agency:_____ Event:_____

I hereby certify that this history is complete to the best of my knowledge. Falsifying information on this form may result in discontinuation of service and/or repayment of services provided.:

Signature:_____Date:_____

DEO reserves the right to re-verify income at any point in time at a minimum of once per year. 2/2021

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Mail: PO Box 814 Dalton, Ga 30722
www.deoclinic.org

Patient Contract - initial each paragraph

_____ CANCELLATION POLICY - I understand that I am responsible for my appointments. I understand that I am responsible for cancelling or rescheduling my appointment as soon as I become aware of a conflict or transportation issue. I also understand that if I cancel a specialty appointment I may have to wait a month or more before the appointment can be rescheduled.

_____ MEDICATION POLICY - Should your Healthcare Provider recommend prescription medications for you, the clinic will strive to guide and educate you towards the best pricing options currently available. This includes local pharmacies, discount programs, and manufacturer promotions. The DEO Clinic does not routinely dispense long term and ongoing medications for chronic conditions. I understand that the DEO Clinic does not dispense or prescribe any narcotic or mental health medications. At times our donated medications MAY be available and appropriate for your SHORT TERM health needs.

_____ LAB TESTS POLICY - I understand that in order for my provider to treat me appropriately, I am responsible for having all labs and/or tests completed prior to my follow-up appointment. I understand that if I do not have labs/tests completed that were ordered by my provider that my appointment may be cancelled until the labs/test are complete to ensure that my visit with my provider is a productive one.

_____ DISABILITY, WORKMAN'S COMP, LAWSUITS, ETC. POLICY - I understand that the DEO Clinic does not fill out forms or write letters making any determination of disability, workman's compensation or complete evaluations for disability applications.

_____ MEDICAL RECORDS POLICY - I understand that I have the right to my medical records or to have them released to the entity of my choosing with my written consent. I understand that if I request a large portion of my record, or my complete record be printed and released to me, that there will be a $5 charge I am responsible for paying prior to receiving my record. I also understand that there is a 48 hour processing period involved with printing my records.

_____ CHANGE IN STATUS POLICY - I agree to report any changes in my income, household status, contact information and insurance status as soon as I am aware of a change.

_____ CONDUCT POLICY - I agree that I will only exhibit behavior that is respectful and appropriate towards volunteers, staff and DEO property. I understand that violation of this policy would result in notification of the appropriate authorities and/or termination of my services with the DEO Clinic.

Patient printed name:_____ Date:_____

Signature:_____

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CONDITIONS, CONSENT AND AUTHORIZATION FOR TREATMENT

CONSENT
I hereby consent to treatment and care by the volunteers at the DEO Clinic. This may include laboratory testing, assessments by physicians, physician assistants, nurse practitioners, nurses and other medical professionals; diagnostic procedures and medical treatments deemed necessary for my well-being by these professionals. I agree to follow the treatment options given to me to the best of my ability.

CONDITIONS
I have given accurate information in qualifying for care and will notify the DEO Clinic if my insurance or financial status changes. I understand that false or misleading information about my insurance or financial status will result in immediate dismissal as a patient and that the DEO Clinic may charge me for services obtained under false pretense.

I understand that the DEO Clinic provides primary care and cannot provide all services offered by specialists or public health agencies.

I understand that psychiatric drugs or narcotic drugs, and many pain medications are not prescribed or dispensed at the DEO Clinic.

I understand that if a DEO Clinic provider refers me to a specialist for additional care, there may be a charge for that care that I am responsible to pay.

I understand that all patient information will be subject to HIPAA privacy rules.

I understand that my previous medical records including visits to Hamilton Medical Center or Convenient Care may be obtained by DEO to improve the quality of my care.

If I am seen in the Emergency Room or other offices, I will request those records be forwarded to the DEO Clinic.

ACKNOWLEDGEMENTS
I acknowledge that I have received a copy of the PRIVACY NOTICE at the DEO Clinic. I have read and understood the contents of this form and agree to follow these conditions to the best of my ability.

Patient printed name:_____ Date:_____

Signature:_____

Witness:_____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your health information may be used by the volunteer members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. An example would be: results of laboratory tests and evaluations in your medical records will be available to all health professionals who may provide treatment or who may be consulted by volunteers.

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

Your health information may be disclosed to public health agencies as required by law. An example would be: DEO is required to report certain communicable diseases to the State's Public Health Department.

Be advised that if you have been treated at the Convenient Care or E.R. of Hamilton Medical Center your records will be accessed to provide continuity of care unless you object by signing here:

DO NOT access my HMC records:_____

Disclosure of your health information or use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written authorization revoking the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke authorization.

Additional use of information: Appointment reminders.

You have certain rights under federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

DEO is required by law to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices.
Privacy officer for DEO Deloris Hefner, Nurse Practitioner

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Release of medical information:

Please list the names of individuals that we may release your medical history to:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

May we leave medical information on your home phone? _____YES _____ NO

May we release information via a fax machine or email? _____YES _____ NO

Fax:_____ E-Mail:_____@_____

May we leave appointment reminders by text? _____YES* _____ NO

*Specify phone number: _____

_____ _____

Signature of patient or guardian Date

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Request for Medical Records/ Solicitud de registros médicos

Facility/instalación(hospital or office):_____

Name/of patient:_____Date of Birth:_____
Nombre del paciente Fecha de nacimiento

Address/Dirección _____

Street/Calle City, State Zip Code/codigo postal

Telephone/Telephono:_____

Dates of service:_____

I, _____ give my permission to release my records to the DEO Clinic, Inc. by on site review, copies or fax.

Signature of patient: _____ Date:_____

Yo, _____ doy mi permiso para entregar mis registros al DEO Clinic, Inc. mediante in situ revisión, copias o fax.

Firma del paciente: _____ Fecha: _____

Additional information:

Medical History Form

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Last Name:_____First Name: _____Middle Initial:_____
Apellido: Nombre

Birth Date:_____SSN/ID: _____Gender:_____ Language:_____
Fecha de nacimiento genero idioma

Address:_____City, State, Zip:_____
Dirección Ciudad, estado, código postal

Email: _____Cell phone:_____Text? Yes No
Teléfono celular

Emergency Contact:	Phone:	Relationship
Contacto de emergencia:	Teléfono:	Relación

Please circle any medical issues past or present: Marque cualquier problema médico pasado o presente:

Alcohol abuse	Anemia	Asthma	Back Problems	Cancer:_____
Colitis	Cough (chronic)	COPD	Diabetes	Drug abuse
Eating disorder	Eye disease	Gallbladder problem	Head Injury	Headache (chronic)
Heart Disease	Hepatitis	Hernia	High blood pressure	HIV/Aids
Migraines	Pneumonia	STD	Sickle Cell trait	Sinus/Allergy
Sleep problems	Smoking	Thyroid	Tuberculosis	Urinary Tract infection

List others:

List hospital visits with cause and approximate dates: (Enumere las visitas al hospital con la causa y las fechas aproximadas):

Family Medical History: List father, mother, sibling or grandparents who had any of these conditions:
Historial médico familiar: Enumere el padre, la madre, los hermanos o los abuelos que tuvieron cualquiera de estas condiciones:

Condition	Family members	Condition	Family members
Arthritis		High Blood Pressure	
Cancer		Kidney Disease	
Diabetes		Thyroid Disease	
Heart disease		Stroke	

Other:

I hereby certify that this history is complete to the best of my knowledge:Por la presente certifico que esta historia está completa, a mi leal saber:

Signature:_____Date:_____ 2/2021