Please put a check mark by the documents you will provide for intake

Proof of Identification (choose one)

- ○ Drivers License or State ID
- ○ Passport

Proof of Residency (choose one)

- ○ Current Utility Bill
- ○ Current Telephone Bill
- ○ Current Car Insurance Bill
- ○ Current Bank Statement
- ○ Other
  (Hospital bills do not count as proof of residency)

Proof of Income (choose one)

- ○ Income Tax W2 or 1099 form
- ○ Current Payroll check stubs for 30 days of work
- ○ Food Stamp Award Letter
- ○ Disability Award Letter
- ○ SSI Award Letter
- ○ Wage statement for no income from Department of Labor
- ○ If married, both you and your spouse will need to provide proof of income from choices above

These documents will need to be provided on an annual basis to continue healthcare

We are a 100% donation-funded healthcare facility. To continue providing high-quality healthcare services, we invite you to make an optional $10 donation at each visit. This donation is not required and will not affect your ability to receive care. All contributions help us continue to serve our community. Thank you for your support!

WILLING HELPERS MEDICAL NEW PATIENT INTAKE DATE: _____

Name: _____ Birth Date: _____SSN:_____

Address:_____

Best Phone Number: _____Email: _____

Sex: Male Female Other: _____ Single Married Divorced Separated Widowed

Sexual Orientation: _____ Ethnicity: ☐ Hispanic ☐ Non Hispanic

Race: ☐ Not Specified ☐ Asian ☐ Black or African American ☐ Native American ☐ White ☐ Mixed

Emergency Contact Name: _____ Number:_____

Why are you here today (What is your main medical problem):_____

What other doctors do you see?_____

Last time you saw a doctor:_____ Last time in hospital_____Why:_____

Preferred Pharmacy: _____

Have you applied for disability? Yes or No Have you applied for medicaid? Yes or No

Food: ☐ Have enough ☐ Don't have enough ☐ Have food stamps ☐ Use food pantries

Transportation: ☐ I have a car that works ☐ *No car / broken* ☐ Have people who can help ☐ *Do NOT have help*

Utilities: ☐ I have water and electricity where I live ☐ I do NOT have water or electricity

SOCIAL HISTORY:

Are you a spiritual person? Yes or No. If yes, are you where you want to be spiritually? Yes or No

How can we help you reach your spiritual goals? _____

Special Needs: Yes or No ☐ Reading ☐ Vision ☐ Hearing ☐ Mobility ☐ Speech ☐ Language

Alcohol Use? Yes or No How Much _____ How Often _____

Nicotine Use? Yes or No How Much _____ Caffeine? Yes or No How Often _____

Substance Use? Yes or No ☐ Marijuana ☐ Meth ☐ Cocaine ☐ Heroin ☐ Other

Exercise: Yes or No How often? _____

Sleep: Hours per night _____ Trouble sleeping: Yes or No Snore: Yes or No

VACCINATIONS:

Tetanus	Yes or No	**Flu**	Yes or No
Hepatitis	Yes or No	**Covid**	Yes or No
Pneumonia	Yes or No		

SURGERIES:

TYPE OF SURGERY	WHEN

MEDICAL HISTORY:

Diabetes	Yes	No	Blood in Urine	Yes	No
High Blood Pressure	Yes	No	Frequent UTI	Yes	No
Low Blood Pressure	Yes	No	Kidney Stones	Yes	No
High Cholesterol	Yes	No	Gallstones	Yes	No
Blood Clots	Yes	No	Kidney Disease	Yes	No
Asthma	Yes	No	Cirrhosis	Yes	No
Pneumonia	Yes	No	Hepatitis B	Yes	No
Bronchitis	Yes	No	Hepatitis C	Yes	No
COPD	Yes	No	HIV	Yes	No
Heartburn/ Reflux	Yes	No	STI /STD	Yes	No
Abdominal Pain	Yes	No	Frequent Diarrhea	Yes	No
Ulcer	Yes	No	Frequent Constipation	Yes	No
Weight Loss	Yes	No	IBS	Yes	No
Weight Gain	Yes	No	Skin Cancer	Yes	No
Chest Pain	Yes	No	Depression	Yes	No
Heart Failure	Yes	No	Anxiety	Yes	No
Heart Attack	Yes	No	Panic Attacks	Yes	No
Seizure	Yes	No	Bipolar	Yes	No
TIA	Yes	No	Arthritis	Yes	No
Frequent Headaches	Yes	No	Back Pain	Yes	No
Severe Dizziness	Yes	No	Leg Pain	Yes	No
Numbness	Yes	No	Gout	Yes	No
Fainting	Yes	No	Glasses / Contacts	Yes	No
Hearing Loss	Yes	No	Cancer	Yes	No
Ringing in Ear	Yes	No		Yes	No

Allergies: _____

WOMEN'S HEALTH:

Last PAP _____ Last Mammogram _____ Last Period _____

☐ Heavy Periods ☐ Painful Periods Method of Birth Control _____

Number of Pregnancies _____ Vaginal Births _____ C Sections _____

Miscarriages / Other _____

MEN'S HEALTH:

☐ Difficulty Starting Urination ☐ Weak Stream ☐ Testicular Pain / Lumps ☐ Erectile Dysfunction

FAMILY MEDICAL HISTORY:

RELATIVE	AGE	DISEASES	LIVING	CAUSE OF DEATH
Father				
Mother				
Sister				
Brother				
Other				

MEDICATIONS:

MEDICATION	DOSE / STRENGTH	INSTRUCTIONS

Willing Helpers Medical Clinic Patient Rights and Responsibilities

Patient **RIGHTS** include:

- The right to be treated with respect and dignity at all times.
- The right to ask questions, voice concerns, and participate in decisions regarding plan of treatment.
- The right to clear, concise explanations of techniques, procedural risks, possible outcomes, and probability of success.
- The right not to be subjected to any procedures without giving voluntary, competent, and understanding consent.
- The right to express feelings of discomfort about sharing medical issues to any staff member during clinic visits.
- The right to privacy and confidentiality regarding both personal and informational data as it pertains to healthcare.
- The right to have cultural, psychosocial, spiritual, and personal values, belief and preferences respected and be free from all forms of abuse, neglect, exploitation, or harassment.

Patient **RESPONSIBILITIES** include:

- The responsibility to complete clinic enrollment application before receiving medical treatment.
- The responsibility to provide advance notification if unable to keep scheduled appointment at the clinic or at a specialist office that you were referred to by the clinic. Appointments should be cancelled no later than noon the day before appointment.
- The responsibility to inform clinic staff of changes to contact information (address, phone number, income, insurance coverage) in a timely manner.
- The responsibility to provide a complete report of all medications that he or she is taking at the time of each clinic visit, including strength, dosage, and frequency. (Bring all medication bottles to each visit).
- The responsibility to notify the clinic at least one week prior to needing refills on medications
- The responsibility to comply with all clinic policies and procedures.
- The responsibility to comply with the treatment regimen.
- The responsibility to follow through with diagnostic tests and procedures within prescribed time frame.
- The responsibility to refrain from abusive language and behavior.
- The responsibility to report unexpected changes in medical condition to the practitioner.

Failure to comply with any of the above could result in loss of clinic privileges. Noncompliance will be documented in the patient's chart and will be reviewed by Clinic Manager and/or Executive Director after three noncompliance entries.

Patient Signature: _____

Printed Name: _____

Willing Helpers Medical Clinic Appointment Cancellation/No-Show/Late Arrival Policy

Thank you for trusting your medical care to Willing Helpers Medical Clinic.

When you schedule an appointment with Willing Helpers Medical Clinic, we set aside enough time to provide you with the highest quality care.

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

If you will be more than 15 minutes late for an appointment, please contact the office to notify us and ensure that you can still be seen that day.

Please see our Appointment Cancellation / No-Show Policy below:

- Effective May 1,2019, a note will be made in the chart of any established or new patient who fails to show or cancel / reschedule an appointment without at least a 24 hour notice.
- Any established or new patient who fails to show or cancels/reschedules an appointment without 24 hour notice for the third time in a rolling year will be dismissed from Willing Helpers Medical Clinic and will not be rescheduled.
- Any established or new patient who is more than 15 minutes late for a scheduled appointment for the third time in a rolling year will be dismissed from Willing Helpers Medical Clinic and will not be rescheduled.
- Willing Helpers Medical Clinic does attempt to remind patients of their visits by phone or email. However, even if you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment.

If you should experience extenuating circumstances, please contact the clinic as soon as possible. You may leave messages with Willing Helpers Medical Clinic 24 hours a day, 7 days a week at 678-625-8317 or at info@willinghelpersclinic.com.

I have read and understand the Medical Appointment Cancellation / No-Show Policy and agree to its terms.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Willing Helpers Medical Clinic Contact Preferences and Receipt of Privacy Practices

Please answer the following questions about your privacy preferences and update the clinic if this information changes:

MESSAGE PREFERENCES

APPOINTMENT REMINDERS: May we leave voicemail, email, or text messages regarding your clinic appointments?

VOICEMAIL:	YES ☐	NO ☐
EMAIL:	YES ☐	NO ☐
TEXT MESSAGE:	YES ☐	NO ☐

MEDICAL AND HEALTH INFORMATION: May we leave voicemail, email, or text messages regarding your health and medical information, including, but not limited to, test results, prescription information and recommendations?

VOICEMAIL:	YES ☐	NO ☐
EMAIL:	YES ☐	NO ☐
TEXT MESSAGE:	YES ☐	NO ☐

FAMILY AND FRIENDS

FAMILY AND FRIENDS: May we discuss your general medical information with your family and friends?

YES ☐ NO ☐ SPECIFIC PEOPLE ONLY (please list below) ☐

Specific family and friends that Willing Helpers may discuss my medical care with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Willing Helpers Medical notice of privacy practices:

Patient Signature: _____ Date: _____

Patient Printed Name: _____