PATIENT APPLICATION FORM

The clinic's hours are as follows:

Monday-Thursday: 8:30am to 7:00pm
Friday: 8:30am to 5:00pm
We are closed from 12:30 to 1:30 each day for lunch.

Eligibility Criteria:

1. Must be a resident of Smyth, Grayson, or Washington Counties
2. Must meet income guidelines

Unacceptable Criteria:

1. You are not a resident of Smyth, Grayson, or Washington Counties
2. If you have any medical insurance of any kind (includes Medicaid, Medicare, and/or Disability Insurance)
3. If income exceeds guidelines

If you feel like that you qualify for our services, please feel free to contact us for an appointment @ (276) 781-2090.

***Patients will be seen by appointment only.**

All services at MLFC are provided free of charge. Patients who are referred to other offices may be charged for those services, but we will do our best to assist with financial assistance applications when possible.

If you are a first time patient, you must provide previous year's tax return and a photo I.D. card.

We provide such services as:

Acute Medical Care (examples include):

1. Colds & Flu
2. Sore Throat
3. Minor illnesses and injuries

Chronic Medical Needs (examples include):

1. Hypertension
2. Diabetes
3. Asthma
4. Thyroid Disorder
5. Laboratory Testing

Feel Free to Contact Us Anytime:

The Mel Leaman Free Clinic is located on the Emory & Henry School of Health Science campus at:

601 Radio Hill Road
Marion, VA 24354
www.melleamanfreeclinic.org
info@melleamanfreeclinic.org
Phone: (276) 781-2090
Fax: (276) 781-0866

Mel Leaman FreeClinic at Emory & Henry College

PATIENT APPLICATION FORM

Patient Name: ___________________________________ Date of Birth: _____________

Address: ____

Social Security # ______-_______-_________ Email: _______________________________

Home Phone: ______________________ Cell Phone:_______________________________

May we leave messages on your answering machine/voicemail? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Race: ☐ Asian ☐ Black ☐ White ☐ Hispanic ☐ Other: ____________________

Name of Employer: ____

Address of Employer: ____ Phone: ________________

☐ Fulltime ☐ Part-time ☐ Seasonal If Unemployed, for how long? ____________

Total number of people in household? _________ Ages: _____________________

Do you receive any public assistance benefits, unemployment benefits, social security benefits, or workers' compensation? ☐ Yes ☐ No If yes, which benefits? ______________________________

Which pharmacy do you prefer? ____

Emergency Contact Name: _______________________ Relationship: _______________________

Emergency Contact Address: ____

Emergency Contact Home Phone #: ____________________ Other Phone #: _________________

Please <u>check yes or no</u> for each question.

1. Are you currently a Smyth, Grayson, or Washington County resident? ☐ YES ☐ NO
2. Are you a military veteran? ☐ YES ☐ NO
3. Do you have any Medical Insurance? ☐ YES ☐ NO
4. Do you have any Prescription Insurance? ☐ YES ☐ NO
5. Do you have Medicaid, Medicare Insurance? ☐ YES ☐ NO
6. Have you filed for disability? If so, when: ____________________ ☐ YES ☐ NO
7. Did you file taxes for the past year? ☐ YES ☐ NO

We MUST have a copy of your most recent 1040 TAX FORM. Without this information, no medications can be ordered. We also need a copy of your Photo ID or Driver's License.

<u>I hereby acknowledge the information given above is true and correct. I authorize the Mel Leaman Free Clinic to verify any information contained in this document for the sole purpose of assessing my eligibility for medical and prescription services. I also agree to provide updated financial information in the future when requested. I recognize that if any information is found to be false or misleading, I will not receive any assistance from the MLFC at any time.</u>

Signature:____Date: ___________________

*****************FOR CLINIC USE ONLY********************

Witness:____Date: ____________________

Mel Leaman FreeClinic at Emory & Henry College

PATIENT APPLICATION FORM

CONSENT FORM

→ In signing this document, I hereby give permission for treatment by the medical and/or rehabilitation staff at the Mel Leaman Free Clinic (MLFC). If any additional testing, labs, x-rays, or any referrals to specialists outside the MLFC is needed, I understand that I may be responsible for payments required by that office. The MLFC cannot be held responsible for any treatment held outside the MLFC.

→ As a patient of the Mel Leaman Free Clinic, I will treat all the volunteers and healthcare providers with respect. I will NOT call or try to contact any of the staff, volunteers, or health care providers at their home or office, or I may be dismissed from the MLFC and no longer be eligible for any of the MLFC's services.

→ I understand it is policy of the Mel Leaman Free Clinic that NO NARCOTICS OR SLEEPING PILLS (such as Xanax, Ativan, Darvocet, Lortab, Klonopin, and/or etc.) will be prescribed to me. I also agree NOT to ask for these types of medications.

→ I hereby consent to have my blood tested, if necessary, to determine whether I have the antibodies to HIV/AIDS in my blood. I understand that the test is performed with minimal risk by withdrawing blood and having that blood tested by an outside lab. There is no alternative test for thatpurpose.

I understand that my medical record maintained by my physician will contain the order for the test and a copy of the results. I understand that if my blood contains antibodies to HIV, which would be a positive result, that my results will be reported to the Virginia Department of Health as required by law. In addition, those health care providers who are directly responsible for my care and treatment will be informed of this result so that they can properly care for me.

I understand that I have an opportunity for face-to-face disclosure of these results and counseling. I understand that it is necessary for me to return to discuss that meaning of these tests and any results with my physician and to receive counseling. I further understand that any information regarding my tests results shall be maintained confidential and will not be disclosed except in accordance to the law.

→ I understand that my medical records must be kept private, and that it is a violation of HIPAA laws for the MLFC to disclose my information to anyone without my written consent.

→ I also understand that information contained in my medical record is available to any person or entity holding a current authorization for release of information signed by me.

→ I understand that students may be involved in my care for training purposes, and that I have the right to refuse to have students involved in my care.

→ I understand it is the policy of the Mel Leaman Free Clinic at Emory & Henry College (MLFC) to not complete paperwork for patients regarding unemployment and SSI/disability applications, claims, inquiries, or similar forms.

I HAVE READ THIS FORM AND I UNDERSTAND IT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND WAS GIVEN ALL EXPLAINATIONS NEEDED.

Signature:____ Date: ____________________

*****************FOR CLINIC USE ONLY********************

Witness:____ Date: ____________________

Mel Leaman FreeClinic at Emory & Henry College

PATIENT APPLICATION FORM

NO SHOW/CANCELLATION/RESCHEDULE POLICY

In order to provide good patient care, we ask that all patients give a **24 hr.** notice to the office if you are unable to keep your scheduled appointment time. This policy has been developed in order to provide same day appointments for those who are sick and need to be seen. If someone makes an appointment and then does not show, cancels, or reschedules, we have then lost an available time that could have been used for a sick patient.

We need to inform you, as per the clinic's policy, that after **3** no-shows, cancellations, and/or reschedules you may be dismissed from all of the Mel Leaman Free Clinic's providers for a period of 6 months. No medications will be dispensed, but prescriptions will be written for the patient to take to a pharmacy to fill the patient's cost. We will try to accommodate your needs as the schedule will allow.

If you are referred to another office or specialty service (including dental hygiene here at the clinic) and you are a no-show after 1 appointment, you will be suspended from any other referrals for a period of 6 months.

Please sign below as affirmation that you have read and understand the clinic's policy regarding no-shows, cancellations, and reschedules.

Signature:____Date: ______________________

*****************FOR CLINIC USE ONLY*********************

Witness:____Date: _______________________