FAITH.Care Employer: _____

Patient Information

First Name:	MI:	Last Name:
Date of Birth:	Social Security Number:	Gender: ☐ Male ☐ Female
Street Address:		Marital Status:
City:	State:	Zip Code:
Home Phone:	Cell Phone:	*Do you consent to receive appointment reminders by text message? ☐ Yes ☐ No
Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Race: ☐ Black/African American ☐ Asian ☐ White ☐ Hispanic ☐ Native American ☐ Other:_____	
Email Address:		

Emergency Contact

Name:	Relationship:_____
Phone Number:	

Insurance Information

Do you have health insurance? ☐ Yes ☐ No	
If yes, what type of insurance? (Check all that apply) ☐ Medical ☐ Dental ☐ Vision ☐ Other:_____	
Do you have prescription insurance to pay for your medication? ☐ Yes ☐ No	
Do you have Medicaid? ☐ Yes ☐ No	Do you have Medicare? ☐ Yes ☐No

Medication Information

Patients must meet household income guidelines to qualify. To apply, please complete the information below and make a registration appointment in the clinic. For details, check our Registration page online.

Household Information

Number of Adults:	Number of Children:
Are you staying in someone else's house? ☐ Yes ☐ No	Relationship:_____
Did you file taxes last year? (If yes please provide a copy of your most recent federal 1040) ☐ Yes ☐ No	

Income Information

Do you receive food stamps? ☐ Yes ☐ No	If yes, amount per month: $_____
Your Employer:	Spouse/Secondary Employer:
Hours Per Week: Hourly Wage:	Hours Per Week: Hourly Wage:
Social Security/Disability Amount Per Month:	Pension Amount Per Month:
Child Support Per Month:	Unemployment Per Week:
Are you dependent on some else's income? ☐ Yes ☐ No	

Acknowledgement of Faith Community Health Policies

**Please initial in the boxes to acknowledge that you've read and accept our policies.*

	While Faith Community Health offers affordable healthcare, it is **not** a free clinic. You are required to pay the appropriate fee(s) for each appointment and service received at this clinic. If complete payment cannot be made, your appointment will be rescheduled.
	You acknowledge and understand that there is a yearly registration/re-registration fee of $10.
	You acknowledge and understand that there is a $10 per month fee for using the clinic's medication office.
	If for some reason you cannot keep an appointment, we have scheduled for you, please call **24 hours** prior to the appointment to cancel or reschedule.
	If you do not give us **24 hour** notice of needing to cancel or reschedule your appointment at our clinic, or with any provider that we have referred you to, it will be counted as a "no show" and documented in your file.
	If you "no show" three times at our clinic or with any other provider that we have referred you to, you will be dismissed as a patient of Faith Community Health for a period of one year.
	ALL "no shows" will result in a $20 fee applied to your account.
	Please be early for your appointment. If you are 10 minutes or more late for an appointment it will be rescheduled, and it will count as a "no show".
	No cell phone usage while with clinic staff (provider, front office, nurse, etc.).
	No smoking, chewing, vaping or inappropriate language in the clinic.
	We **do not** fill or prescribe narcotic medications.

I have been informed of the above Faith Community Health policies. By signing this form, I indicate a clear understanding of these policies and agree to accept the consequences of not following them.

I have been offered a copy of the Faith Community Health Notice of Privacy Practices, and thereby have been informed of my rights as a client of Faith Community Health.

In addition, I permit Faith Community Health to disclose protected health and financial information to Dispensary of Hope and their agents, auditors, and monitors

I certify that to the best of my knowledge, the information I have provided is complete and accurate in every respect. I understand that false statement of omission of facts may disqualify me from eligibility to be a client of Faith Community Health.

_____ _____

Print Name Date of Birth

_____ _____

Signature Date

610 South 6th St Branson, MO 65616 Phone: 417-336-9355 Fax: 417-334-4427

Faith Community Health General Consent for Care and Treatment

Patients of Faith Community Health,

Your rights are our priority. For this reason, you will be informed about your condition and the recommended course of treatment, which includes all exams, diagnostics, and surgical procedures so that you may make an informed decision whether or not to undergo any and all treatments with knowledge of the risks associated with care. At this point in your care, no specific treatment plan has been recommended. This general consent form serves to obtain your permission to perform the evaluation necessary to determine the appropriate procedure(s) for identified condition(s).

This general consent to treat form provides Faith Community Health with your permission to perform reasonable and necessary examinations, testing, diagnostics, and treatment. By signing below, you are indicating that you recognize:

1. This consent is continuous in nature even after a specific diagnosis has been made and treatment has been recommended.
2. You consent to treatment at this clinic, or any other satellite clinic, provided by Faith Community Health.

This consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

You have the right to discuss the treatment plan with your provider about the purpose, potential risk(s), and health benefit(s) of any diagnostic procedure ordered for you. If you have any concerns regarding any test or treatment which has been recommended by your provider, we encourage you to seek clarifications.

I voluntarily request the providers and all other staff of Faith Community Health to perform reasonable and necessary examination(s), testing, and treatment(s) for the condition(s) which have brought me to this practice. I understand that if additional testing, invasive or interventional procedures are recommended; I will be asked to read and sign a detailed informed consent form prior to obtaining those services.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Printed Name of Patient	Patient Date of Birth
_____	_____
Printed Name of Responsible Party (If not the patient)	Relationship to Patient
_____	_____
Signature of Patient or Responsible Party	Date
_____	_____
Signature of Clinical Staff Witness	Date

610 South 6th St Branson, MO 65616 Phone: 417-336-9355 Fax: 417-334-4427

HIPAA Release of Information

I authorize Faith Community Health to discuss medical and billing information with the following person(s).

Name:	Relationship to Patient:	Phone Number:
Name:	Relationship to Patient:	Phone Number:

Note: This form does not give the above referenced individual(s) permission to make health care decisions for the patient or entitle them to paper copies or electronic access of the patient's medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above, unless the patient has an opportunity to object and does not (documented), or if it is reasonable to infer that the patient does not object, such as when a patient brings a spouse into the room when treatment is being discussed.
Exception: If the release is needed in emergency situations

By signing this form, I indicate a clear understanding of the above information.

_____ _____
Patient's Printed Name Patient's Date of Birth

_____ _____
Printed Name of Responsible Party (If patient is under 18 years of age) Relationship to Patient

_____ _____
Signature of Patient or Responsible Party Date

610 South 6th St Branson, MO 65616 Phone: 417-336-9355 Fax: 417-334-4427