HARMONY
HEALTH CLINIC

ATTENTION: New Patients!

New Patient Application Requirements

Applications must be returned COMPLETED with ALL documentation before an appointment can be made. Return this application Monday-Friday between 9 AM - 1 PM

Requirements:

- You must live and/or work in Pulaski County
- Your income is below 300% or more below the Federal Poverty Line
- **Must have NO INSURANCE**

Please bring the following to complete your new patient application:

- Picture ID
- Proof of residence
  - Please bring a current utility bill with your name and address
  - If you are currently living in a shelter, please bring a letter from the shelter confirming that you are living there.
- Proof of income (Please bring 1 months' worth of ALL sources of income such as SNAP benefits, pay stubs, SSI benefits, unemployment statement, etc.)
- If you have been denied Medicaid or you have pending Medicaid, please bring a denial letter or proof that your Medicaid is pending.
- If you have no income, please bring a copy of your most recent federal tax return.

If unemployed, bring any and all of the following that apply to you:

- Current social security/benefits letter
- SNAP/food stamps award letter
- Unemployment statement
- Retirement/pension award letter
- Veterans benefit award letter
- Child support for each child
- Self-employed income verification (bank statement)
- TEA/TANF award letter
- DHHS statement
- Other household income - identify source of income
- If you are living with someone who is taking care of your necessities, that individual must sign the last page of the application and provide a utility bill with his/her name and address

Must provide: Picture ID, Proof of Residency, & Proof of Income

PATIENT APPLICATION

GENERAL INFORMATION

Full Name: ______________________________ SSN#: _________________________

I preferred to be called: ____

Street Address: ____

City/State/Zip: _____________________ Date of Birth:______/_____/______

Cell Phone: ___________________________ Is it okay to text you at this number? ☐Yes ☐No

Home/Other Phone(s) where we can reach you: ________________________________

Email Address(es): ____

Is it okay to leave a message with information about your appointments, medical condition, and other information at all of these numbers and emails? ☐Yes ☐No

What languages do you speak fluently? ____________________________________

Do you need or want interpreter services? ☐Yes ☐No If yes, what language?__________________

Do you have any cultural or religious beliefs we need to be aware of in providing you care? ☐Yes ☐No
If yes, please describe:____

Race / Ethnicity: (Check all that apply)

☐ American Indian or Alaska Native
☐ Black / African American
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ Hispanic or Latino
☐ White / Caucasian
☐Other: ____

For Clinic Use Only: Date Rec'd: _________________Date Approved/Declined: ____________

Your current gender identity: ☐ Female ☐ Male ☐ Trans Woman/MtF
☐ Trans Man/FtM ☐ Gender Queer ☐ Nonbinary ☐ Choose not to disclose
☐ Another gender description: ______________________________

Sex you were assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Unknown
☐ Not disclosed on birth certificate ☐ Choose not to disclose ☐ Another description: _________

Do you think of yourself as: ☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual
☐ Bisexual ☐ Asexual ☐ Don't know ☐ Choose not to disclose ☐ Something else: ________

What are your preferred personal pronouns: ☐ She/Her ☐ He/Him ☐ They/Them
☐ Other/Something else: ______________________________

Do you want or need help to have your legal sex, gender, or name changed? ☐ Yes ☐ No
Referred for legal services to: ______________________________

EMPLOYMENT AND FINANCIAL INFORMATION (SEE "CALCULATING MONTHLY INCOME")

Employment Status: ☐Full Time ☐Part-Time ☐Retired ☐Disabled ☐Unemployed

My Total Gross Household Income (income before taxes or deductions) calculated for *all Household Members age 19 and older* is $_________________________.

I have attached the following income verification documents to this application (check all that apply):

	Pay checks/Pay stubs (4 most recent)		Bank Statement (2 most recent)
	Letter/Telephone Contact with Employer		Court Order (settlement, alimony, child support, other)
	Tax Return, W-2, or Form 4506T		Letter from State Unemployment
	Verification from Public/Private Agency (TANF/ADC, Food Stamps, Shelter, Social Security, SSI, etc.)		Self Declaration of Income (SEE "PATIENT SELF DECLARATION OF INCOME")
	Letter from Employer of Pension/Retirement Award		Other (Rent $ Received, etc.)

MY HOUSEHOLD SIZE

The number of people in my household is: _________________

Calculating Household Members/Family Size: The number of household members or family size is determined based on the number of individuals residing in the household who are related and/or **economically interdependent**. (Example: Those who have zero income and are living with relatives and/or all dependents listed on IRS 1040 tax form are considered related and/or economically interdependent.)

HEALTH AND DENTAL INSURANCE

Do you have health insurance? ☐Yes ☐No If yes, what type of insurance?_________________

Do you have dental insurance? ☐Yes ☐No If yes, what type of insurance?_________________

Have you applied for Medicaid? ☐Yes ☐No If yes, when?

What was the response to the Medicaid application? ☐ Approved ☐ Denied ☐ Waiting to find out

RESIDENCY INFORMATION

I certify that I live in Pulaski County, Arkansas: ☐Yes ☐No

I live in the United States AND/OR work in Pulaski County, Arkansas. ☐Yes ☐No

I have attached the following residency documents to this application to show that I live in the United States (check all that apply):

	Driver's License		Another Official Document
	Car Registration		Letter from Shelter
	Copy of Lease or Rental Agreement		Utility Bill
	Copy of Mortgage Coupon		School Record
	Letter from Roommate or Landlord		

EMERGENCY CONTACT INFORMATION

Name: ____ Cell Phone: __________________

Relationship to Patient: ______________________________ Home Phone: _________________

Name: ____ Cell Phone: __________________

Relationship to Patient: ______________________________ Home Phone: _________________

MEDICAL INFORMATION AND HISTORY

What brings you in to see the doctor or dentist?

____

____

____

Are you under the care of a doctor or dentist right now? ☐Yes☐No

How would you rate your overall physical health?

☐Very Poor ☐Poor ☐Average ☐Good ☐Very Good ☐Excellent

Please list any chronic medical problems that you have (such as diabetes, high blood pressure, heart disease, or other problems). ____

____

Have you been or are you being treated for mental health issues?

☐Never

☐Currently being treated

☐Previously treated but not currently being treated

If current or previously treated for mental health issues, please explain diagnosis and treatment:

____
____
____

Have you ever been hospitalized? ☐Yes ☐No

If yes, please list the reason you were in the hospital and dates below.

____

____

____

Have you ever had a major operation? ☐Yes ☐No

If yes, please list any major surgeries and dates of surgeries below.

____

____

____

Please list any medications you are currently taking and dosage instructions below.

____

____

____

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetic ☐Acrylic ☐Metal

☐Latex ☐Sulfa Drugs ☐No Allergies

Please list any other allergies below.

____

____

SUBSTANCE HISTORY

Do you drink alcohol?

☐Never used

☐Currently: what type, how much, and about how often? ___________________________

☐Previously but not currently. Quit date:______/____

Do you use tobacco or any type of nicotine? This includes cigarettes, chew, vaping, etc.

☐Never used

☐Currently: what type, how much, and about how often? ___________________________

☐Previously but not currently. Quit date:______/____

Do you use illegal, recreational, or any kind of controlled substances or street drugs?

☐Never used

☐Currently: what type and about how often? ______________________________________

☐Previously but not currently. Quit date: ____/____

IF YOU CURRENTLY HAVE OR PREVIOUSLY HAVE HAD A VAGINA/UTERUS/BREASTS:

Age of first period: __________ # of pregnancies: ________ # of live births: __________

Are you on birth control? ______ Are you nursing? _________ Are you pregnant? _______

Date of last mammogram, if any: ___________ Date of last Pap smear, if any: ______________

PATIENT CERTIFICATION & CONSENT

INFORMATION CERTIFICATION

I certify that the information I have provided in my application is accurate, complete, and true to the best of my knowledge and belief. I understand that even if my application is approved, services are not guaranteed. I understand that my financial and residency status must be updated at least once per year in order to continue receiving services. However, if my financial situation changes or I obtain health insurance, my eligibility status will need to be re-evaluated and I may no longer qualify for services. I understand that it is my responsibility to notify the clinic or health care center of any changes in my financial situation or insurance status.

Printed Name: ______________________________

Signature: __________________________________ Date: ______/______/________

MEDICAL AND DENTAL CONSENT

I give my consent to participate in the Medical, Dental, Laboratory, Pharmacy, and any other programs provided by Harmony Health Clinic. To the best of my knowledge, I have answered the above questions truthfully.

Printed Name: ______________________________

Signature: __________________________________ Date: ______/______/________

DISABILITY CLAIMS ACKNOWLEDGEMENT

I understand that Harmony Health Clinic does NOT treat patients for work-related illnesses or injuries and will not perform assessments for disability claims.

Printed Name: ______________________________

Signature: __________________________________ Date: ______/______/________

PATIENT APPOINTMENT ATTENDANCE POLICY ACKNOWLEDGMENT

I understand as a patient of Harmony Health Clinic I must take responsibility for not missing scheduled appointments. I understand that it's important for me to keep my appointments to allow staff to monitor my health and medications through a physician's recommended treatment plan. I will make every effort to call to cancel or reschedule at least 24 hours in advance of my appointments. If I do not call in advance, I understand that I may be referred to a different clinic after three missed appointments.

Printed Name: ______________________________

Signature: __________________________________ Date: ______/______/________

PATIENT DRUG ASSISTANCE PROGRAM AGREEMENT

(Appointment of Harmony Health Clinic as Agent)

To receive many free prescription medications, you MUST read, understand, agree to, and sign the following agreement:

1. I certify that the information I have provided in my application is accurate, complete, and true to the best of my knowledge and belief. I understand that even if my application is approved, services are not guaranteed. I also understand that other documents may be required to provide proof of income. If my financial situation changes or I obtain health insurance, my eligibility status will need to be re-evaluated. I further understand that it is my responsibility to notify the clinic or health care center of any changes in my financial situation. I give permission to verify my income through the Department of Social Services, Social Security Administration, my employer, Veterans Administration and any other company, business, or organization from which I receive income.

2. By signing the enclosed application, I authorize representatives of Harmony Health Clinic (HHC) (including but not limited to employees, contractors, and/or volunteers) to ask and receive necessary information about me, my health conditions, and my prescription needs from my health care providers; to complete and sign applications for medication assistance on my behalf; to act as my agent for purposes for applying for prescription drug or other types of patient assistance, to receive prescription drugs, medical supplies, or equipment on my behalf; to share this information with auditors, pharmaceutical companies, and others as required; and to take any other actions necessary to secure prescription drugs or other patient assistance for me.

3. I hereby affirm that all information I have provided to HHC is true and correct in all material respects for purposes of determining my eligibility for services from HHC and from any and all prescription drug assistance programs as well as general treatment and any and all other patient assistance programs. I authorize HHC to verify any information I have provided. I agree to notify HHC within ten (10) days if I obtain health insurance; if I become qualified for Medicare, Medicaid, or other federally funded health coverage; or if my financial situation improves such that I may have become ineligible to receive services from HHC or its prescription drug assistance program partners.

Printed Patient Name: ______________________________

Patient Signature: __________________________________ Date: ______/______/________

OR

______________________________________ ______/____/_______

Signature of Patient Representative Date

______________________________________ ____________________________

Relationship to Patient Authority to act on Patient’s Behalf

PATIENT NOTICE OF VOLUNTEER HEALTH PROFESSIONAL IMMUNITY

The purpose of this notice is to inform you of state and federal laws that may affect your ability to sue volunteer health professionals who provide health care services to you at Harmony Health Clinic for malpractice. Volunteer health care professionals who provide services to you at Harmony Health Clinic may be covered by the state and federal laws described in this notice.

Harmony Health Clinic is registered as a free or low-cost health care clinic in accordance with Ark. Code Ann. Section 16-6-201 et seq. and related regulations issued by the Arkansas Department of Health. Meaning that any volunteer health care professional who renders health care services at Harmony Health Clinic shall not be liable for any civil damages for any act or omission resulting from the rendering of health care services to you, unless the act or omission was the result of the health care professional's gross negligence or willful misconduct.

A federal law relating to the operation of free clinics known as the Federal Tort Claims Act (FTCA) 28 U.S.C. Section 1346(b), 2401(b), 2671-80, provides the exclusive remedy for damage from personal injury. This includes death, resulting from the performance of medical, surgical, dental, or related functions by any Harmony Health Clinic volunteer health care practitioner who the United States Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA who have provided a required or authorized service under Title XIX of the Social Security Act (i.e. Medicaid) at a free clinic site or through other off site programs or events carried out by the free clinic. See U.S.C. Section 233 (a), (o).

Please note that Harmony Health Clinic does not accept patients who currently have insurance for the type of care they are seeking. Harmony Health Clinic will treat Medicaid-eligible patients as long as they are actively pursuing coverage, and only until such time that they receive coverage. Harmony Health Clinic does not receive Medicaid Reimbursement for any services provided.

Acknowledged:

Printed Patient Name: ______________________________

Patient Signature: __________________________________ Date: ______/______/________

OR

______________________________________ ______/____/_______

Signature of Patient Representative Date

______________________________________ ____________________________

Relationship to Patient Authority to act on Patient's Behalf

Harmony Health Clinic

Telehealth Consent Form

Patient Name (last, first): _______________________________

DATE OF BIRTH: __________________

Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Client health records
- Live two-way audio and video
- Output data from health devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care by enabling a client to remain in his/her provider's office (or at a remote site) while the provider obtains test results and consults from practitioners at distant/other sites.
- More efficient client evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the providers and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information;
- In rare cases, a lack of access to complete health records may result in interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent to The Use of Telehealth

I, ______________________________, have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

Signature of Client (or person authorized to sign for client):

____

Witness:

____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of Harmony Health Clinic's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Harmony Health Clinic and how I may obtain access to and control this information.

Printed Patient Name: ______________________________

Patient Signature: __________________________________ Date: ______/______/________

OR

_______________________________________ ______/____/_______

Signature of Patient Representative Date

_______________________________________ ____________________________

Relationship to Patient Authority to act on Patient's Behalf