Christ Clinic

A Free Community Medical Clinic

Consent for Treatment

Patient's name: _____

Address: _____Telephone:_____

If patient is a child, please complete following information:

Mother or Father's name: _____

Address: _____Telephone:_____

I hereby consent to the provision of care, diagnosis and/or treatment by Christ Clinic, Inc. 3920 S. Shields, Fort Collins, CO, and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence.

_____ _____

Signature of Patient or Person Authorized to Consent* Date

Relationship if not patient:

*If this consent is signed by someone other than the patient, it must be signed in the patient's presence.

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Receipt of New Patient Forms

I have received a copy of the Christ Clinic Patient Rights and Responsibilities form and the Christ Clinic Notice of Privacy Practices.

X _____Patient _____Date/Time

X _____Witness _____Date/Time

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PATIENT RIGHTS AND RESPONSIBILITIES

Christ Clinic is completely staffed by volunteers. This is a free healthcare service. You are expected to pay nothing. We believe every person is made in the image of God. We are all equal in His eyes. Our time with you today is an expression of our love for Jesus. With His death on the cross, he paid the price so we all may enter into a relationship with Him and have life everlasting.

It is our desire to address your healthcare needs to the best of our ability with the resources we have. We attempt to treat the complete person not simply physically, but emotionally, mentally, socially and spiritually. It is important for you, the patient, to understand that we can best help you with illness when we consider you as a complete person.

All services at Christ Clinic are free. We do not pay for services outside of the clinic at hospitals, laboratories, consultants' offices or other healthcare providers.

We consider it a privilege to serve you through Christ Clinic.

Patient Rights

Christ Clinic has adopted the following statement of patient rights. This list includes but is not limited to the following:

As a patient you can expect:

- To be treated with respect, with courtesy, with consideration and in a safe environment.
- To be informed of your rights as a patient in advance of, or when discontinuing the provision of care. You may appoint a representative to receive this information should you so desire.
- To be offered prayer and/or spiritual counseling. The acceptance of the free medical care and services of Christ Clinic does not obligate any patient to accept prayer or spiritual counseling.
- To receive quality care regardless of age, sex, race, religion, disability, sexual orientation, diagnosis, economic or educational background.
- To actively participate in the development and implementation of your plan of care (physical, spiritual, emotional, mental and social aspects), and actively participate in the decision making process, including the right to refuse care.
- To have your personal privacy maintained at all times
- To have confidential treatment of all communications and records pertaining to your care.
- To be free of all forms of abuse, harassment and coercion.
- To be free of seclusion or restraints not medically necessary.
- To be informed of outcomes of care, including potential outcomes.
- To receive information regarding your care (diagnosis, treatment plan, risks, benefits and alternative, and prognosis) in a manner that you can understand.

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Patient Responsibilities

Christ Clinic expects all patients, including you:

- To provide accurate and complete information concerning your present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
- To make it known whether you do or do not clearly understand the course of your medical/spiritual care and treatment plan and what is expected of you.
- To review and comprehend the clinic policies on patient's rights and responsibilities.
- To ask for clarification if you do not understand any policy, form, questions, procedure, diagnosis, treatment, prognosis or recommendation.
- To accept the consequences of deliberately refusing to follow the recommendation of the physician, or his designate.
- To be considerate and respectful of the Christ Clinic staff and property.
- To recognize the impact that your lifestyle may have on your personal health and accept the consequences for the outcomes if you do not follow the care, service or treatment plans.

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Christ Clinic Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

As a Christ Clinic patient some of your health information is collected and maintained by this clinic. The clinic is required by law to maintain your privacy and the security of your health information and to provide you with this Notice of Privacy Practices. This Notice describes how your health information may be used and shared, and explains your privacy rights. The clinic is required to follow the terms of this Notice. We may, however, change our privacy practices and the terms of this Notice in the future, and those changes may effect all health information maintained by the clinic. If our privacy practices change, you will be mailed a new Notice.

PERMITTED USES AND SHARING OF YOUR HEALTH INFORMATION:

Treatment: We will use and share your health information to ensure you are provided medical treatment and services. For example, Christ Clinic may share your health information with a doctor or hospital that is giving you health care.

Payment: We will use and share your health information to pay for your medical treatment. Christ Clinic is a free medical clinic so you will receive no bills for the care we provide ourselves.

Health Care Operations: We will use and share your health information for clinic operations necessary to make sure our clients receive quality care. For example, Christ Clinic may share your health information with an outside contractor to review hospital and doctors' records to assess the care you received.

Future Communications: We may use your health information to mail you information on health care programs and health care choices.

Legal Requirements: We will share health information about you when required to do so by federal or state law.

To Avoid Harm: We may use or share your health information to prevent serious threat to your health and safety or the health and safety of others.

Research: Under certain circumstances, we may share your health information for research purposes. All research projects must be approved, and the project must keep your information confidential.

Public Health: We may share your health information with public health agencies to prevent or control the spread of diseases.

Health Oversight Activities: We may share your health information to a health oversight agency for activities authorized by law. These activities may include, for example, audits, investigations, and inspections.

Lawsuits and Disputes: We may share your health information in response to a valid judicial or administrative order.

Coroners, Medical Examiners and Funeral Directors: Consistent with applicable law, we may share your health information to a coroner, medical examiner, or funeral director, so that they may carry out their duties. Your health information may also be shared to ensure organ and tissue donation.

Workers Compensation: We may share your health information with programs that give benefits for work-related injuries or illness.

National Security and Intelligence Activities: We may share your health information to authorized federal officials for activities related to national security and special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may share your health information to the correctional institution or law enforcement official for the purposes of health care or safety.

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Other uses or sharing of your health information will be made only with your written authorization.

YOUR HEALTH INFORMATION RIGHTS:

Right to See and Get a Copy of Your Health Information: You may see and get a copy of your health information and billing records by making a written request to Christ Clinic's medical records department at this address. We can only provide those records that were created for or on behalf of Christ Clinic. You may not see or get a copy of any psychotherapy notes or information prepared solely for use in a civil, criminal, or administrative legal action.

Right to Request that We Correct Your Health Information: If you feel that the health information we have provided to you is incorrect or incomplete, you may ask us to amend the information by making a written request to Christ Clinic's Medical Director. In certain cases, the clinic may deny your request to amend your information.

Right to a List of Disclosures Made of Your Health Information: You have the right to a list of those instances in which we have shared your health information, other than for treatment, payment, and health care operations, or when you specifically authorized the clinic to share your information. Your request must be in writing to the clinic's Medical Director.

Right to Request that Your Health Information be Communicated in a Confidential Manner: You may request, in writing to the Christ Clinic's Medical Director that your health information be provided in a confidential manner, such as sending mail to an address other than your home. The clinic will honor reasonable requests.

Right to Request that We Not Use or Share Your Health Information: You have the right to request that we not use or share your health information for treatment, payment, or health care operations, or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. Your request must be in writing to the Medical Director, and we will consider your request but we are not legally required to accept it.

Right to a Copy of the Notice: You may ask for a copy of this Notice anytime.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions about your privacy rights, would like additional information about something in this Notice, or would like to file a complaint because you believe your privacy rights have been violated, you may contact the
Medical Director at:
Christ Clinic
3920 S. Shields
Fort Collins, CO 80525
970-481-2390

You may also file a complaint with the Secretary of the United States Department of Health and Human Services at:
Secretary
U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201

CHRIST CLINIC CANNOT RETALIATE AGAINST YOU IN ANY WAY IF YOU FILE A PRIVACY COMPLAINT.

This Notice is effective as of September 3, 2012

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Acknowledgement of Non-continuous Medical Coverage

Christ Clinic is a free community medical clinic staffed by volunteers that holds sessions each Monday evening from 6 to 9 PM. All patient visits are by appointment only.

Christ Clinic provides health care only during those hours. The clinic does not provide medical coverage at other times. There are no oncall providers.

Therefore, in the event of an emergency do not attempt to contact the clinic but call 911. If you have an urgent problem which cannot wait until your next regularly scheduled appointment, contact an Urgent Care Center and follow their instructions.

By signing this form, I recognize that as a patient of Christ Clinic there is not medical care available from clinic staff except during regularly scheduled appointments on Monday evenings. I will call 911 for emergencies and I will contact an Urgent Care center for problems that cannot wait until my next scheduled appointment.

Signed_____

Date_____

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FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Sample Patient Notice of Limited Liability for FTCA Deemed Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Independent Contractors

Notice to Patients

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner, board member, officer, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board member, officer, employee, or independent contractor who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

Acknowledged:

_____

(Patient signature)

_____

(Patient name, printed legibly)

_____

Date

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Patient History

Date: ___/___/____

Name_____ **Sex: ___ Male ___ Female**
Address_____ **City**_____ **Zip**_____
Phone_____ **Date of birth**_____ **Age**_____
Emergency Contact _____ **Phone** _____**Relationship** _____

Christ Clinic provides service to patients regardless of insurance status, but if a specialty referral is necessary, insurance may be required for that service. Please indicate whether you have any medical insurance. ____Yes ____No

Name of Family Dr. or Clinic:_____
Date last seen by Dr.:_____ Date of last physical:_____ Currently being treated? Y or N
Type of medical problems currently being treated:_____
Medication allergies: _____Yes _____No List:_____
Other allergies_____

Medications: List all currently being taken or discontinued in the last 30 days. Include birth control pills and over the counter medications also. _____None taken List below:

Name of medication	Dosage	How often taken	Doctor	How long taken?	Prescription or Over the counter?

Pregnant: __Y or __N Breast feeding: __Y or __N First day of last period:_____

MEDICAL HISTORY: PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

___AIDS	___Bronchitis	___Nerve problems	___Abnormal bleeding
___HIV+	___Fainting	___Heart problems	___Gallbladder disease
___Cancer	___Cataracts	___Liver disease	___Headaches
___Stroke	___Jaundice	___Low Blood Pressure	___Kidney stones/disease
___Asthma	___Diabetes	___Seizures/Epilepsy	___Alcohol/Drug Abuse
___Anemia	___Hepatitis	___High Blood Pressure	___Psychiatric Problems
___Ulcers	___Pneumonia	___Severe Arthritis	___Gonorrhea/Syphilis
___Genital Herpes	___Colitis	___Bloody Stools	___Thyroid/Goiter
___Rheumatic Fever	___Glaucoma	___Heart Attack	___Urine Infections
___Nervous Problems	___Hemorrhoids	___Emphysema	___Tuberculosis
___Lupus	___Blood disease	___Heart Murmur	___Night sweats
___Recent weight loss	___Smoking	___Birth defect	___Depression

Smoker ___No ____Yes How many packs per day? _____ for how many years?_____
Past surgeries/injuries/hospitalizations and dates:_____

_____

_____

What concerns do you seek care for today?_____