Community Free Clinic
A Beacon for Medical & Mental Health in Washington County, Maryland

249 Mill Street
Hagerstown, MD 21740
Phone: 301-733-9234
Fax: 301-733-9205
www.mycommunityfreeclinic.org

New Registration Checklist

Dear Valued Patient,

Welcome to the Community Free Clinic, Inc, (CFC). Please read the following information carefully. Use this check list to make sure you have all the required documents BEFORE you come to the CFC for registration.

Registration is completed Monday through Thursday 8:30AM until 11:30AM and 1:00PM until 4:00PM. Your first appointment can be scheduled by phone arriving 30 minutes prior to complete your new patient packet and verify your documents. If you have any questions please call our courteous and helpful staff.

Eligibility: To receive services at the Community Free Clinic

1. Be a documented citizen of Washington County, Maryland
2. Be medically uninsured

Registration Requirements: Please bring all of the following documents for the registration process.

1. Completed Patient Registration Packet
2. Valid government issued Driver's License, Photo ID or Identification card
3. Most recent IRS Form 1040, 1040A, or 1040EZ or IRS Verification of Non Filing Status
    - The services of the Community Free Clinic are not based on patient income, but we do assist patients in enrolling in income based discount programs, particularly for prescription medications.
4. Proof of Washington County Residency

    Must include the patient's name and residence address in Washington County, Maryland
    - Utility, telephone, cell phone or cable or satellite television bill
    - Checking or saving account statement
    - Property tax bill or receipt
    - Residential rental contract
    - First class or priority mail from the federal, state or local government
    - Other forms as approved by Executive Director or designee

The services at the Community Free Clinic are provided at **NO CHARGE** due to the generosity of the citizens, businesses and local government entities of Washington County, Maryland. Because we do not accept any health insurance companies, including Maryland Medicaid and Medicare we are not eligible for any direct State or Federal Funding.

Donations help to fund the day to day operations of the Community Free Clinic. Any donations that you are willing to give will be welcomed. **Donation boxes are located in the lobby of the Community Free Clinic** or contact the Executive director to set up a drop off.

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PATIENT DEMOGRAPHICS

Name *(Last, First, Middle.)*:			**PT#**:
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Questioning		**PT Height**: _____	**Med Rec#**:
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			**DOB**:
Race: ☐ America Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White **Ethnicity**: Are you Hispanic or Latino ☐ Yes ☐ No			
Social Security Number:			**Citizen Status** ☐ US Citizen ☐ US Resident
# Persons in Household: _____ **# of Children in household**: _____			**Annual Household Income** $
Do you have any type of health Insurance coverage? ☐ Yes ☐ No ☐ Not Sure			**Veteran Status** ☐ US Veteran ☐ Non Veteran
Contact information: We may need to contact you with urgent or critical lab results. Please keep this information updated!	Home Phone		Emergency Contact
	Cell Phone		Relationship
	Work Phone		Phone
Address: *(Address)* *(City, State ZIP)*			
Employer:			May we contact you at work if needed? ☐ Yes ☐ No
Employer Phone:			
Washington County Proof of Residency: ☐ Yes ☐ No Source: _____			Verified by: _____

I certify that under penalty of perjury the above information is complete and correct as record.

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Review Date	Initial	Notes

Review Date	Initial	Notes

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HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.):*	**DOB:**

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications **Latex Allergy** (circle one) Yes No

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH & AGE AT DEATH		AGE	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH & AGE AT DEATH
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Brothers & Sisters	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Mother's Side*		
	☐ M ☐ F		**Grandfather** *Mother's Side*		
	☐ M ☐ F		**Grandmother** *Father's Side*		
	☐ M ☐ F		**Grandfather** *Father's Side*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Name *(Last, First, M.I.):*	**DOB:**

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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Patient Assistance Program

Name (Last, First, MI):	DOB:

Dear Patient,

Many pharmaceutical (medication) companies provide medications to patients for free, based on their household income. As a patient of the Community Free Clinic, Inc. we will require you to enroll in any and all applicable Patient Assistance Programs (PAPS) for which you may be eligible. Doing so allows the Clinic to obtain your brand-name medications at no cost to you or to the Clinic.
The services of the Community Free Clinic, Inc. are not based on patient income. The following **ARE** requirements of the PHARMACEUTICAL (medication) companies:

- Most Recent Federal Income Tax Return (IRS Form 1040)
  - If you did not file a Federal Tax Return in the last Tax Year, you must obtain an IRS Letter of Non-Filing. **Complete IRS Form 4506-T Line 7: Verification of Non-filing.** These requests are generally processed in 10-business days.
- Additionally, these documents *MAY* be needed:
  - Four (4) most recent pay-stubs (if applicable)
  - Any State or Federal Support Program or Assistance Documents
  - Court Ordered Child Support Documents (Paid and/or Received)
  - Social Security Income Documents
  - Retirement or Pension Income Documents
  - Unemployment Documents

Again, this information is NOT required by the Community Free Clinic, but by pharmaceutical companies that supply us with your medications. Failure to provide the necessary documents may result in you NOT receiving your medication.

Thank you for your cooperation,
Community Free Clinic Inc.

Please read carefully and sign:

I am aware of the above requirements and I understand that if I fail to provide the information listed above, I may be denied free medications. I certify that I am not medically insured, nor do I have any public assistance medical insurance coverage. I have received a copy of the Clinic's Rules & Regulations as well as the Clinic's No-Show Policy.

I understand and will abide by both documents. I have had an opportunity to discuss my questions with a Clinic staff member.

Patient Signature _____ Date _____

Patient Printed Name _____

Legal Guardian Signature: _____ Date _____

Legal Guardian Printed Name: _____ *Only as needed*

Witness Signature _____ Date _____

Witness Printed Name _____

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PHARMACY AVAILABILITY

Patient Name:_____ DOB:_____ PT#: _____
(Please print neatly)

As a patient of the Community Free Clinic, Inc. I understand that some of my medications, either prescription or Over-The-Counter (OTC) are provided free of charge. I accept these medications and acknowledge that a self-pay pharmacy is not conveniently available to me for the following reason(s):

Please check all that apply:

☐ Financial Hardship ☐ Transportation ☐ Medication Not Covered

☐ Other (Please Specify): _____

Patient Signature: _____ Date_____

Patient Printed Name:_____

Witness Signature: _____ Date_____

Witness Printed Name:_____

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Patient Name:_____ DOB: _____ PT. # _____

CONSENT FOR MEDICAL TREATMENT

I hereby give my consent to the Community Free Clinic, Inc. to provide medical care appropriate to my health condition. I consent to the examination of my body, removal of tissue and its disposal if needed and the passage of needles through my skin for purposes of diagnosis, treatment or disease prevention. All procedures will be within the standard of care of outpatients. Any unusual or experimental procedures will require separate consent from me. I further understand that I may still refuse consent of or revoke consent of any exam, test or treatment at any time and for any reason.

PRESCRIPTION DRUG DISPENSING WAIVER

I understand that all free medication dispensed to me is being given to me in containers that are NOT childproof. I further understand that it is my responsibility to secure these medications away from the reach of children or other persons requiring supervision. In the event that a child, other person requiring supervision, pet, etc. gains access to these medications and is harmed in any way, I will hold harmless the Community Free Clinic, Inc. Its staff, volunteers, providers and Board of Directors as well as any other involved parties. I accept full responsibility for accepting these medications as is, and to protect the safety of those around me.

ATTENDANCE POLICY

The Community Free Clinic values the time of our patients, volunteers, providers and staff. To that end, our expectation is that all patients be on time for their scheduled appointments. By my signature, I agree to abide by this policy at all times. The following actions will result in patients being issued a no show.

1. Arriving after the start time of your appointment. (If you arrive 15 minutes late or later to your appointment you will not be seen that day and issued a failed appointment).
2. Missing any specialist appointment without at least 48-hour notice. (Our specialty providers come on an as needed basis and volunteer their time, we respect that and want to make sure their time is well used).
3. A pattern of cancelling appointments without 24-hour notice. The Community Free Clinic recognizes that emergencies occur that prohibit patients from providing 24 hr-notice. Should a patient experience an emergency (for example, inclement weather, contagious illness, death, serious injury and /or hospitalization) they are asked to contact the CFC as soon as possible to inform the team of the cancellation and reason for cancellation.

1st No Show: You are placed on a 12-month probation period where your case is tracked for attendance violations.

2nd No Show: Your case will be reviewed by our directors where the Community Free Clinic will determine if treatment should continue. From this review your case could be more restrictive scheduling, suspension or discharged from the Community Free Clinic

Any violence or verbal abuse of staff or volunteers at the Clinic will result in IMMEDIATE and PERMANENT dismissal. No exceptions.

Patient Signature: _____ Date_____

Patient Printed Name:_____

Witness Signature: _____Date_____

Witness Printed Name: _____

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RULES AND REGULATIONS

Dear Patient,

Welcome to the Community Free Clinic, Inc! Please read the following information carefully. If you have any questions, please be sure to discuss them with a Clinic Staff Member.

• Your healthcare is provided free of charge due to the generosity of the citizens, businesses and local government entities of Washington County, Maryland who financially support the Community Free Clinic. Because we do not participate with ANY health insurance companies, including Maryland Medicaid, we are not eligible for any direct State or Federal Funding. Donations fund this Clinic; your donations to help support the Clinic are always welcome.

• To be eligible for care at the Community Free Clinic, Inc., you must be medically uninsured and a current resident of Washington County, Maryland. You will be required to provide proof of residency.

• Although the Clinic does have paid employees, the majority of the care and services provided here is through the hard work and efforts of our volunteers. This includes providers, clinical and office staff.

Respectful behavior while at the Clinic is expected. No loud speech, foul language, arguing, threats or abuse of any kind will be tolerated. This type of behavior WILL result in immediate dismissal and permanent loss of privileges at the Clinic.

• At each appointment, you will be asked to verify your home mailing address and contact phone numbers. This is an important step in ensuring we can contact you regarding appointments and healthcare issues.

• The Clinic is generally open Monday through Thursday from 8:30AM until 5:30PM. The Clinic is closed from 12:00PM to 1:00PM for lunch. We do NOT have "on-call" providers or services. If you need assistance during off hours, please dial 911 or go to your nearest Emergency Room or Urgent Care Center.

- In some cases, appointments will be scheduled outside of regular Clinic hours based on the availability of our volunteer providers (generally they come after their regular office hours for late evening appointments).
- Patients are responsible for scheduling their follow-up appointments on their way out.
- In the event that you have an acute or sudden medical illness during regular business hours, please contact the Clinic for the next available appointment. If a provider is available, we will see you as soon as possible, and in some cases that same day.

Remember, YOUR healthcare is YOUR responsibility. Do NOT run out of medication because you forgot to schedule an appointment.

• Unfortunately, the Clinic will not be able to meet the health needs of every patient. We are **NOT** pharmacy, although we do our best to help patients secure the medications they have been prescribed. While the services provided by Community Free Clinic, Inc. are not income based, pharmaceutical companies have several assistance programs that are. The Clinic requires all patients to enroll in appropriate Patient Assistance Programs to help secure their medications at no cost. If you do not provide all the necessary documentation to enroll in a PAP, we will **NOT** be able to secure your medication for you. **Please do your part to ensure your medication needs are met.**

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No exceptions.

Referrals to outside providers and/or clinics:

- If referred to an outside specialty provider or clinic, there may be a charge for the referral visit. The Clinic has no control over financial arrangements between its patients and outside provider offices or clinics. We encourage our patients to seek out financial assistance options with each provider or facility.
- Failure to keep a schedule consult/specialist visit will result in your losing privileges for any further referrals through the Community Free Clinic, Inc.

Laboratory Studies (Blood Work)

- Most laboratory studies ordered by a provider at the Community Free Clinic, Inc. are paid for by the CFC.

If your provider orders a test, based on your medical condition, that the Clinic cannot pay for, you will be responsible for the fee for the test. We encourage our patients to seek out financial assistance options with each provider or facility. Patients are expected to have all laboratory studies completed BEFORE any scheduled follow-up appointments or outside referrals. Appointments may be cancelled if laboratory studies are not completed in time.

Advanced Imaging (X-Rays, CAT Scans, Ultrasounds, MRI's, etc.)

- The Community Free Clinic does NOT pay for these studies. It is the responsibility of the patient to make financial arrangements with the imaging center for any radiology testing. Patients are expected

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to have all advanced imaging completed BEFORE any scheduled follow-up appointments or outside referrals.

Appointments may be cancelled if advanced imaging is not completed in time.

Inclement Weather Policy

- The Community Free Clinic, Inc. follows Hagerstown Community College with relation to weather-related delays or closings. Please listen to local tv/radio media for weather-related delays or closings.

General Rules & Regulations

- Please be patient and courteous while waiting to be seen. We understand your time is important; we will do our best to keep appointments on time and advise you of any extended wait-times.
- Please, no eating or drinking inside the Clinic.
- **Cell phone usage is strictly prohibited.** This includes using a cell phone for texting, taking pictures, etc.
- If you are more than 15 minutes late for any scheduled appointment, you will be required to reschedule, and you will be issued a "no-show" for the missed appointment.
- Smoking is not permitted inside the Clinic.
- Weapons are not permitted inside the Clinic or anywhere on Clinic property.

I have read and understand the rules and regulations of the Community Free Clinic.

Patient Signature: _____

Patient Printed Name: _____

CFC Witness Signature: _____

CFC Witness Printed Name: _____