SCOTLAND COMMUNITY

Health Clinic

Scotland Community Health Clinic provides routine care such as annual physicals and PAP smears, chronic disease management for diseases such as high blood pressure, high cholesterol, diabetes and asthma. Some medications are free and some medications are not. We assist when possible with imaging services, blood work or tests that are referred from our clinic. We operate solely from funds donated and grants.

This clinic does **not** provide dental care, eye care, mental health care, specialty care, or chronic pain management. We do not provide prescriptions for narcotics, sleep medication or pain medication.

As a patient at the clinic, we ask that you do the following things:

- You MUST notify the clinic immediately if you begin receiving Medicaid, Medicare or private insurance.
- **Bring all your medications in their most recent bottles to your provider visits (or your appointment may be canceled) Do not bring insulin.**
- Notify your local drug store at least **2 weeks before your medicine runs out** if you are down to "no refills" on your bottles. The drug store will fax us a "refill request" and the provider will sign and fax it back to the drug store if he/she chooses to refill it. If you are using our mail order pharmacy MedAssist, you must call in your own refills when you are down to 10 days of medication remaining.

Rudeness or profanity will not be tolerated and may be cause for immediate dismissal from care at this clinic. Remember that some of our staff here are volunteers that are here to help provide you with free health care. All people deserve respect.

If you are found to be eligible to be a patient here, we look forward to serving you as a patient. If you have any questions or concerns during the time you are a patient at this clinic, feel free to contact me directly.

Sincerely,

Andrew Kurtzman
Executive Director

Revised 9/2015

1405-B West Boulevard • Post Office Box 2050 • Laurinburg, North Carolina 28353
Phone (910) 276-9912 • Fax (910) 276-9913

# SCOTLAND COMMUNITY HEALTH CLINIC

## Questionnaire for New and Recertifying Patients

**Revised 9-17-15**

Date: _____ Name _____
Last First Middle

Date of Birth _____ Social Security Number _____

Marital Status: (check one) Married _____ Separated _____ Divorced _____ Single _____

Date of Birth: _____ Age: _____ Gender: Male___ Female ____
Race: _____
What county do you reside in? _____
You must provide an ID or Driver license with this package. If your ID does not match your current address, bring in a recent bill with your current address on it. Hospital bill, electric bill, phone bill, etc.

Address: Street _____
(where you receive your mail) PO Box _____
City _____ State_____ Zip Code _____

Phone Numbers: ***NOTE: DO NOT LIST NUMBERS THAT DO NOT RECEIVE CALLS!***
Home phone: _____ Cell phone: _____
Emergency contact person: _____ Emergency contact# _____
Email address (optional): _____

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a. Are you receiving health Services at the Scotland County Health Department? _____ YES _____ NO

d. Do you have any private health insurance? _____ YES _____NO

e. Do you have any public health insurance such as Medicare or Medicaid? _____ YES _____ NO
If you have a Medicaid Denial Letter, please bring it with you.

f. Have you applied for insurance under Affordable Care Act (Obamacare)? _____ YES _____NO

*If No*, please explain why not: _____

_____

Are you currently employed? _____ Yes ____ No If yes, where? _____
Full or part time? _____ Can you get insurance through your employer? _____Yes _____No
Do you have an employed spouse? __ Yes _ No If yes, employed where? _____

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- If you work or your spouse works, you **MUST** bring in a copy of a **month's worth of recent check stubs** that are in a row to be considered as a patient at this clinic! **If you file taxes, we must get a copy of your return.** (Form 1040 or 1040EZ) If you have your own business, please bring in a copy of your Schedule C.

- If you get Social Security, Disability, Retirement or any monthly check, you **MUST** bring in **the most current year's copy of your statement** in order to be considered as a patient at this clinic!

- If you do **NOT** have any monthly income at all, you MUST **get the support letter signed included in this packet** by whoever helps with your day-to-day needs in order to be considered as a patient at this clinic.

Name: _____

Please list your **current household monthly household wages** $_____

Do you or your family members have any **other sources of income** such as:

| | | | | |
|---|---|---|---|---|
| Unemployment | _____YES | _____NO | Monthly Amount Received | $_____ |
| Social Security | _____YES | _____NO | Monthly Amount Received | $_____ |
| Disability Income | _____YES | _____NO | Monthly Amount Received | $_____ |
| Retirement Income | _____YES | _____NO | Monthly Amount Received | $_____ |
| Work First (WFFA) | _____YES | _____NO | Monthly Amount Received | $_____ |
| Food Stamps | _____YES | _____NO | Monthly Amount Received | $_____ |
| Other | _____YES | _____NO | Monthly Amount Received | $_____ |

**Total Monthly Household Income** $_____

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**Family Size** (Number of people living in same house as you, including yourself) :_____Only put "1" in this box if you live alone.

(Please list below the names, ages and relationship of everyone currently living in same house as you)

| **Name /Age/Relationship** | **Name /Age/Relationship** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Falsifying information will result in denial of care at this clinic.**

I understand that the answers to the questions above will be used to determine my eligibility for clinic services and that my signature below indicates that I have answered them truthfully and to the best of my knowledge correctly. I understand that if I cannot provide documentation for income that is listed above, that I will not be eligible to receive services at this clinic.

**My signature below authorizes Scotland Community Health Clinic to make inquiries and receive information to verify criteria noted above regarding my residency, financial status, and availability of health insurance.**

Applicant's Signature _____ Date:_____

Eligibility Worker's Signature _____ Date: _____

Eligibility for Services Approved/Denied by:_____ Date: _____

Scotland Community Health Clinic
Patient Medical Information Sheet

Patient Name _____ *DOB:* _____ Phone:_____
Sex: _____ SSN: _____ Mobile:_____
Mailing Address: _____
Street City Zip
IN CASE OF EMERGENCY CONTACT the following person(s)

| Name | Relationship | Phone No. |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Current Medical Conditions or Complaints (please list):

_____ _____
_____ _____

Current Medications (please list all – including pain medications)

_____ _____ _____
_____ _____ _____
_____ _____ _____

DO YOU HAVE MEDICATION ALLERGIES: ___ YES ___NO If yes, what?_____
Are you being treated for pain or chronic pain? ___YES ___ NO If yes, where?_____

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Number of ER visits last year? _____ Number of hospitalizations last year? ____ Where? _____

Surgeries (please list all) with approximate date of surgery

_____ _____ _____

***Have you ever been diagnosed with:***
*(Circle if yes)*
High blood pressure
Diabetes
Heart Disease
Breast Cancer
Prostate Cancer
Colon Cancer
High Cholesterol
Lung conditions
Cataracts
Fibromyalgia
Alzheimer's
Chronic Pain
Arthritis
Thyroid Problems
Kidney Disease

***Has anyone in your family had?***
*(Circle if yes and note relation to you)*
High blood pressure
Diabetes
Heart Disease
Breast Cancer
Prostate Cancer
Colon Cancer
High Cholesterol
Arthritis
Thyroid Problems
Kidney Disease

Do you smoke cigarettes? Yes _____ No _____ If yes, how much per day/week?_____
Do you drink alcohol Yes _____ No ____ If yes, how much per day/week _____
Do you smoke marijuana? Yes_____No___ If yes, how much per day/week _____
Do you use street drugs? Yes_____No____ If yes, what drugs and how often_____
*For Women*: Number of Pregnancies: ___ Number of Live births: __
Number of Miscarriages: ___

# RELEASE OF MEDICAL INFORMATION

I hereby authorize Scotland Community Health Clinic **to request and receive** medical information from the record of all physicians or facilities listed as part of my patient questionnaire or found to be necessary by my provider. **YES____ NO ____ (check one )**

If no, please list below any providers whom we may request necessary information.

Name of physicians/facilities:

_____ _____

_____ _____

_____ _____

I hereby authorize Scotland Community Health Clinic **to send** medical information on my behalf to the physicians or facilities deemed necessary by my provider and the following physicians or facilities:

_____ _____

_____ _____

If you think we have violated your privacy rights you may file a written complaint with the clinic's Executive Director who serves as our privacy officer. You may also send a written complaint to :

The US Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

We will take no retaliatory action against you if you file a complaint about our privacy practices.

I have received a copy of SCHC HIPPA and privacy act policies.

Signed _____ Date _____

Print Name_____

Please list below anyone who can access your medical information (do not list physicians).

Name Relationship

_____ _____

_____ _____

_____ _____

Scotland Community Health Clinic
1405-B West Blvd.
P. O. Box 2050
Laurinburg, NC 28353
Phone: 910-276-9912
Fax: 910-276-9913

# Receipt of Food Stamps Verification

**To: Department of Social Services FNS Division**
FAX: 910-277-2402

**Re: Verification of Receipt of Food Stamps for:**

**Name:** _____ **Birth Date:** _____ **SSN:** _____

**Address:** _____

By my signature below I authorize the Department of Social Services FNS to release information to Scotland Community Health Clinic regarding the amount of food stamps I currently receive per month.

**Signed:** _____ **Date:** _____
Signature of person seeking eligibility

**Do not write below this line. For Department of Social Services use only**
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**DSS Verification:**

Amount per month in Food Stamps: $_____

County providing food stamps: _____

Verified by: _____ Phone: _____
DSS Representative

Please FAX information back to 910-276-9913.

SCOTLAND COMMUNITY Health Clinic

## Food, Shelter, and Financial Support Verification

Date: _____

I, _____, provide financial support/assistance
Name of person providing support

to help _____ with rooming, boarding,
Name of patient

and miscellaneous expenses each month.

I am neither legally responsible for this individual's bills nor do I buy

prescription medications for this individual.

Signature of person providing support:_____

Printed name: _____ Relationship to patient:_____

Address:_____

Phone number: _____

Additional comments:_____

_____

_____

Form **4506-T**
(Rev. August 2014)
Department of the Treasury
Internal Revenue Service

# Request for Transcript of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

**Tip.** Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

| | |
|---|---|
| **1a** Name shown on tax return. If a joint return, enter the name shown first. | **1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)** |
| **2a** If a joint return, enter spouse's name shown on tax return. | **2b Second social security number or individual taxpayer identification number if joint tax return** |

**3** Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

**4** Previous address shown on the last return filed if different from line 3 (see instructions)

**5** If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

**Caution.** If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

**6** **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

**a** **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

**b** **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

**c** **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

**7** **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

**8** **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

**Caution.** If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

**9** **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. 2014

**Caution.** Do not sign this form unless all applicable lines have been completed.

**Signature of taxpayer(s).** I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

| | | |
|---|---|---|
| | | Phone number of taxpayer on line 1a or 2a |
| **Sign Here** ▶ **Signature** (see instructions) | Date | |
| ▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust) | | |
| ▶ **Spouse's signature** | Date | |

Scotland Community Health Clinic **HIPPA Privacy Rule** *Patient Copy* Rev 8/13/13

Purpose of the Privacy Notice: This notice describes how your medical information may be used and disclosed, and how you can get access to the information if needed. Please review carefully.
***A detailed notice of privacy practices is available in the clinic waiting room or ask the receptionist.***
Definitions:

Protected Health Information (PHI)-
Any individually identifiable information about a person's past or present physical or mental health condition, which is created or received by a covered entity, In any form including written oral or electronic.

Covered entity – a health care provider, health care clearinghouse or health plan that conducts specified electronic transactions involving PHI

Business Associate – any external iIndividual or entity who performs a a function on behalf of a covered entity that involves the use or disclosure or PHI

Treatment – the provision, coordination or management of care to a patient.

Health Care Operations – activities of covered entities related to operating and managing the entity

Personal Representative – someone who has the legal authority to act on behalf of an individual with respect to the Privacy Rules' requirement.

Workforce – employees, volunteers, trainees and others whose work for a covered entity is under the entity's 'direct control, whether or not they are paid.

## Permitted Uses and Disclosures

* Your confidential healthcare information may be released to other healthcare professionals within SCHC for the purpose of providing you with quality health care.
* Your confidential information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
* Your confidential information may be released to other healthcare providers in the event you need emergency care.
* Your confidential information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device.
* Your confidential information may NOT be released for any other purpose than that which is identified in the SCHC Notice of Privacy Practices. *Please read detailed notice available in the clinic waiting room or ask the receptionist.*
* For requests other than those listed above, your written authorization is required. You may revoke your permission to release confidential information at any time.
* You may be contacted by the SCHC to remind you of appointments, healthcare treatment options, or other services that may be of interest to you.
* You have the right to restrict the use of your confidential information. However, the SCHC may choose to refuse your restriction if it is in conflict of providing you with quality care or in the event of emergency information.
* You may be contacted by the SCHC for the purposes of raising funds to support the SCHC operations.
* You have the right to restrict the use of your confidential information. However, the SCHC may chose to refuse your Restriction if it is in conflict of providing you with quality care or in the event of an emergency situation.
* You have the right to review, receive copies of or make amendments to your confidential information.
* You have the right to request an accounting of disclosures of your confidential information.

You have the right to complain to Scotland Community Health Clinic if you believe your rights to privacy have been violated.
If you would like to file a complaint with the SCHC Privacy Officer, please contact:
Executive Director
Scotland Community Health Clinic
1405 B West Blvd
Laurinburg, NC 28352
(910) 276-9912

**I consent to the uses and disclosures of my health information as outlined above and in the SCHC Notice of Privacy Practices.**

Signature of Patient:_____ Date_____

SCOTLAND COMMUNITY Health Clinic

# No Show Policy

Provider and staff time is reserved for your appointment. We take your appointment time very seriously. Please honor your commitment to your health care by showing up on time. Providers get paid for your allotted appointment if you show or do not show, so please be considerate of the funds donated by others to help you with your healthcare.

You will be given an appointment card at each visit. **You are responsible for keeping up with your appointment card**. A suggestion is to place the card on your refrigerator.

You are responsible for keeping your scheduled appointments and for arriving on time. If you arrive later than 10 minutes after your scheduled appointment, you may be asked to reschedule your appointment in order to accommodate patients that have arrived on time.

As a courtesy we try to remind you of each appointment by phone.

**You will be charged a $10.00 fee if:**

- If you fail to show for your appointment without notifying the clinic at least 30 minutes before your scheduled appointment that you are unable to keep your appointment. If the clinic is closed please leave a voice message.
- If you miss your appointment because you failed to check your voice messages.
- If you miss your appointment because your family member forgot to give you the message about your appointment reminder.
- If you miss your appointment because you changed your phone number and did not notify us of your number change OR if your phone is disconnected.
- If you miss your appointment because your phone does not receive incoming calls. **PLEASE DO NOT GIVE US PHONE NUMBERS THAT DO NOT RECEIVE INCOMING CALLS!**

The $10.00 will be expected prior to scheduling your next appointment. If your annual enrollment package is overdue you will not be seen for labs or office visits and your medication orders will be cancelled. It is important to stay on top of your enrollment once notified.

With a 2nd missed no show appointment you will no longer be able to receive patient services or prescription assistance for 6 months. At the end of 6 months you may have to reapply for eligibility if it has been more than a year since your last visit.

If you fail to show without notice for three (3) appointments, your name will be removed from our patient list and you will not be eligible for future care at this clinic.

Your signature below indicates that you understand the above policy.

Patient signature: _____ Date: _____

*Policy in effect since June 2014* *Form updated Sept 2015*

Scotland Community Health Clinic
1405-B West Blvd.
Laurinburg, NC 28352
(910) 276-9912

# Limited Power of Attorney

I _____, appoint ***Nancy Stanton* or her designee**, agents of the *Scotland Community Health Clinic Medication Access and Review Program*, to be my attorney-in-fact, to sign applications and letters for me for the purpose of obtaining prescription medications for me at low cost or no cost, through pharmaceutical manufacturers' prescription assistance programs. This power of attorney will expire one year from date of signature below.

_____ Date _____

Patient Signature

_____ Date _____

Prescription Assistance Advocate Signature

_____ Date _____

Witness Signature