Bernard Healthcare/Free Clinic of Franklin County **Date:** ______________

Name______________ ______________ ______________ SSN______________
LAST **FIRST** **MIDDLE**

Address______________________ Town______________ Zip__________

Home Phone ______________ Cell Phone______________ Birth date______________

Email______________________________

Emergency Contact Name______________ Phone# ______________ Relationship__________

How did you hear about us? ______________________________

(Are you?) Male ______ Female ______ Transgender ______

Are you a Citizen or Permanent Legal Resident of the United States? YES or NO

Race: White____ Black ____ Hispanic/Latino ____ Mixed ____ Other ______

Highest Education Level: High School ____ GED ____ College ____ Post-Graduate____

Marital Status: Married____ Single ____ Divorced ____ Widowed ____ Separated ____ Partnered ____

Are you employed: Full Time____ Part-time____ Retired____ Disabled ____ Seasonal ____

Unemployed, looking for work____ Unemployed/Homemaker/Not looking for work____

Are you a Veteran: YES or NO *Does your employer offer Health Insurance? __________

Do you have: Medicare A ________ Medicare B ________ Medicaid QMB ________

Medicaid ____ Private Medical/Hospital/Health Insurance ______ GAP ________

No Insurance __________

Have you ever applied for Medicare or Medicaid? YES or NO

If yes, reason for Medicare or Medicaid Denial______________________

Do you have any assistance with medication costs? YES or NO If yes: ______________

Do you have prescription drug coverage? YES or NO If yes: ______________________

Monthly Income: Wages ________ SSI ________ SSDI ________ Pension ____________

Child Support/Alimony________ Food Stamps________ Other______________________

****Total Monthly Income ______________________________
(Wages, Social Security, Pension before taxes, Include interest earned from savings/investments)

Saving/Checking Account Balance______________ Value of Investments __________
(Include Stocks, Mutual Funds, Stock and Bonds)

****Total of Savings/Checking and Investments/Liquid Assets ______________________

Monthly Household Income

Only list member of household if married to **OR if patient is a dependent on persons taxes**

	Name	Relationship	Age	Monthly Income	Income Source
1.					
2.					
3.					
4.					
5.					
6.					

***Total Household Size:** ______________________

***Total Monthly Income:** ______________

*** x 12 months:** ______________

*** % Percentage:** ______________

***Documentation (copy of proof)**

What Document received and Date on document showing when received

Document Type ______________________________ **Dated**________________

- *I authorize the **Bernard Healthcare/Free Clinic of Franklin County Inc.,** to share my protected health information with **Rx Partnership** and appropriate pharmaceutical companies, as necessary, to obtain my prescribed medication and to audit the performance of the clinic.*

The information used is to obtain medications as prescribed by the physician and for audit purposes. I do understand that I may revoke this authorization by written request.

By signing this document, I attest: The information I have given is correct to the best of my knowledge. I agree to notify the Clinic of any changes in my financial, household, and/or insurance situation. I do not have health insurance except as explained. I am a resident of Franklin County, Virginia. I understand I will need to provide proof/documentation of income to the Clinic prior to service, and at least annually thereafter.

____ ____________________

Signature Patient/Guardian **Date**

____

Screener/Witness

***Screener should review with staff before patient leaves to determine eligibility for all or partial services.**

Rev 02/04/2020

Bernard Healthcare/Free Clinic of Franklin County

Patient Consent Form

Name ______________________________ **Date of Birth** ____________________

Allergies ____________________________**Social Security #**____________________

Service Consent: I am requesting care at the **Bernard Healthcare/Free Clinic of Franklin County**. This request gives **Bernard Healthcare/Free Clinic of Franklin County** staff and medical care provider's permission to perform physical exams and routine testing including collection of specimens for testing.

All procedures will be explained to me prior to procedure. Procedures will be performed as directed by a physician. I may refuse any recommended treatment, testing or procedures.

Any surgical procedure will be explained to me by the **Bernard Healthcare/Free Clinic of Franklin County** physician and a new consent form signed including the date, medical provider and procedure to be performed.

By signing this document I authorized treatment by the **Bernard Healthcare/Free Clinic of Franklin County** staff or physician.

In order to provide you with the best possible care the **Bernard Healthcare Center/Free Clinic of Franklin County** occasionally sends text messages, emails and phone messages for reminders, follow ups and concerns etc. Below choose your preferred method:

☐ **Appointment reminders (automatic) Phone:** ____________________

☐ **Text Messages** **Phone:** ____________________

☐ **Voice Messages** **Phone:** ____________________

☐ **Email** **E-mail:** ____________________

☐ **None of the above**

Signature: ______________________________

Witness: ______________________________

Date: ______________

Rev 02/04/2020

Bernard Healthcare/Free Clinic of Franklin County
P.O. BOX 764
ROCKY MOUNT, VIRGINIA 24151
540-489-7500

HIV TESTING DEEMED CONSENT

As of health care provider, we required by 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

- If one of our health care professionals, workers, or volunteers should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV, the “AIDS” virus). A physician or other health care provide will tell you the result of the test.
- If you should be directly exposed to blood or body fluids of one of our health care professionals, workers or volunteers in a way that may transmit disease, that person’s blood will be tested for infection with human immunodeficiency virus (HIV, the “AIDS” virus). A physician or other health care provider will tell you and that person the result of the test.

I have read and I understand the HIV consent statement:

Signature: ______________________________ **Date:** ______________

PATIENT OR LEGAL GUARDIAN

PHARMACY CONSENT

I understand that my medications may be dispensed in non-child resistant containers.

Signature: ______________________________ **Date:** ______________

Witness: ______________________________ **Date:** ______________

Bernard Healthcare Center/Free Clinic of Franklin County
Patient Guidelines

Attention: You are responsible for knowing the following information! Please read carefully. Please ask questions if you do not understand.

GENERAL RULES:

_____ No food or drink is allowed in the patient areas. Please put all trash in the trash cans.

_____ Appropriate behavior is expected at all times. Patients are to remain in the waiting room until called. Parents are responsible for monitoring their children. No running, jumping or unsafe behavior is allowed. Inappropriate behavior by a patient, patient's family or friend, will result in patient being asked to leave. The incident will be reviewed to consider future service.

_____ **The Clinic** will provide the best possible care for all patients.

_____ **The Clinic** is not an emergency facility. If you have a medical emergency, go to the Hospital Emergency Room or call 911. **The Clinic CANNOT** pay for emergency room visits.

_____ You are responsible for informing **the clinic** about changes in **address, phone number, insurance status, and income.**

_____ As a patient, we ask that you keep and organize all of you paycheck stubs, tax forms, and benefit letters for yourself and your household. This information must be documented at each annual re-registration.

_____ **To continue refilling prescriptions, your registration must be active. Registration must be completed every 12 months, and attend doctor visit within 6 months.**

_____ Prescription(s) and/or sample medications(s) may be ordered by the physician. **There is a $3.00 processing/handling fee for each prescription and/or 30 day supply of sample medication given.** Any **special ordered** medications cost is your responsibility. This fee is due at the time of your visit.

_____ Pick up **AVAILABLE REFILLS** Monday-Thursday 8:00 a.m. to 4:30 pm.
We close daily 12:00 p.m. to 1:00 pm for lunch. You must re-order your medication by 3:00 p.m. Wednesday to receive refill on Thursday same week. Anything ordered after 3:00 p.m. Wednesday will not be filled until the next Thursday. **No Auto Refills**

_____ **The Clinic** does not provide second opinions.

_____ **The Clinic** does not assume responsibility for charges incurred at Specialists or for certain special diagnostics. It is the patient's responsibility to inquire about possible fees prior to seeing the physician/specialist.

_____ Diabetic patients are required to attend patient education programs to be eligible for reduced cost diabetic testing supplies.

_____ Appointments should be cancelled at least 24 hours prior to the appointment time by calling 540-489-7500. Please clearly leave your name, phone number, and appointment date and time. If you miss any 3 appointments without calling, you will be seen only in walk in clinic.

DONATIONS:

**** **The Clinic** depends on volunteers for their help and depends on donations from the community in order to provide you with services. We ask that, when possible, you make a donation to help keep **The Clinic** going. Any amount is always appreciated. ****

______________________	______________________	__________
Patient Signature	**Eligibility Screener Signature**	**Date**

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