Bernard Healthcare/Free Clinic of Franklin County

www.bernardhealthcare.com

Registration Application **Today's Date:** _____

1. Applicant Information

Is this your: 1st Time Application ☐ Renewal Application ☐

Name: _____ _____ _____ SSN: _____
(Last Name) (First) (MI)

DOB: _____

Address: _____ Town: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ How did you hear about us? _____

Emergency Contact: _____ Phone#: _____ Relationship: _____

Are you? Male ☐ Female ☐ Transgender ☐

Are you a Citizen or Permanent Legal Resident of the United States? Yes ☐ No ☐

Race: African –American ☐ Caucasian ☐ Hispanic/Latino ☐ Mixed ☐ Other _____

Education: Elementary ☐ High School ☐ GED ☐ College ☐ Post Graduate ☐

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower ☐ Partnered ☐

Monthly Income: Wages _____ SSI _____ SSDI _____ Pension _____

Child Support/Alimony _____ Food Stamps _____ Other _____

Total Monthly Income _____ (include Monthly wages, SSI, SSDI, Pension before taxes)

Do You have any Drug Allergies? Yes ☐ No ☐ If so, _____

2. Eligibility Information

Do you have Health Insurance? Yes ☐ No ☐ **Do you have Pharmacy Insurance?** Yes ☐ No ☐

If you have Health Insurance what kind do you have? _____

Are you a Veteran? Yes ☐ No ☐ Are you Employed? Yes ☐ No ☐

Do you receive Child Support ? Yes ☐ No ☐

Do you receive Food Stamps? Yes ☐ No ☐ Did you file Tax Return last year? Yes ☐ No ☐

Have you applied for Disability? Yes ☐ No ☐ Have you applied for Medicaid? Yes ☐ No ☐

3. Household Members

Household = Spouse/Significant Other + Tax Dependents

Name (First Last)	Relationship	Age	Monthly Income	Income Source
1.			$	
2.			$	
3.			$	
4.			$	
5.			$	
6.			$	
Total in Household: _____			_____	**Total Household Income**
Monthly Income from Section 1:			_____	**Total Monthly Income**
Checking Account			*Total(s) x 12 Months	
Savings Account		Total in Checking/Savings $_____		%

4. Proof of Income

Attach all items below to this application (check box received)

- ☐ **PHOTO ID –** a copy of your drivers license or other photo identification
- ☐ **PAYSTUBS** – last/previous months paystubs of everyone working in the household OR a "Statement of Income from Employer" form from your employer with GROSS earnings for the previous month.
- ☐ **SELF-EMPLOYED** – complete /sign/date a "Self-Employed Statement" form **AND** make sure to include your Schedule C from your most recent tax return.
- ☐ **BENEFITS/INVESTMENTS/OTHER INCOME** – copies of any benefits checks and /or bank statements for all Investments, Social Security, Disability, Unemployment, Child Support, Alimony, Pensions, Interest payments, etc.
- ☐ **Tax Return – 1040 form** of your most recent tax return.
- ☐ **Zero Income** – applicants with Zero income must complete/sign/date a "Zero Income/"Food and/or Shelter Letter" form. If you are living off of savings, you will need a copy of your bank or savings account statement.
- ☐ **Release of Info/Income Verification –** If receiving public assistance or you have no/limited income, then complete/sign/date the "Release of Info/Income Verification from the DSS" form.

Patients Signature: _____ Date: _____

Screeners Signature: _____ Date: _____

5. Patient Consent

(read and check boxes for consent)

☐ I certify that all statements contained herein are true and correct and subject to investigation. I authorize the Bernard Healthcare Center/Free Clinic of Franklin County 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.

☐ As a healthcare 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 healthcare 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 healthcare provider will tell you the result of the test.
- If **you should** be directly exposed to blood or body fluids of one of our healthcare 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 healthcare provider will tell you and the person the result of the test.

I have read and I understand the HIV consent statement

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

☐ I am requesting care at the Bernard Healthcare Center/Free Clinic of Franklin County. This request gives the Clinic 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 t me by 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 CENTER/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. Choose your preferred method below:

Appointment reminders (automatic) ☐

Voice Messages ☐ No contact ☐

Text Messages ☐

Email address _____

Patients Signature: _____ **Date:** _____

Screeners Signature: _____ **Date:** _____

6. Patient Guidelines

Bernard Healthcare Center/Free Clinic of Franklin County

General Rules for all Patients

- ☐ 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. Patient will remain in the waiting room until called. It is the parents responsible to monitor 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.
- ☐ Bernard Healthcare Center/Free Clinic of Franklin County will provide the best possible care for all patients.
- ☐ Bernard Healthcare Center/Free Clinic of Franklin County is not an emergency facility. If you have a medical emergency, go to the Hospital Emergency Room or call 911. **Bernard Healthcare Center/Free Clinic of Franklin County CANNOT PAY** for emergency room visits.
- ☐ Patients responsibility to inform Bernard Healthcare Center/Free Clinic of Franklin County about changes in their **Address, Phone Number, Insurance Status, and Income**.
- ☐ To be a **Active Patient** it is your responsibility to have all necessary documents required to **Re-register each Year** and you **must see doctor within 6 months** to continue getting refills on prescription(s).
- ☐ Prescription(s) and /or sample medication(s) can be ordered by our physician. Be aware there is a $3.00 processing/handling fee for each prescription and/or sample medication given. Any special ordered medications is your responsibility to pay. Fee is due at the time of your visit.
- ☐ Patient responsibility to re-order medication(s). All prescription refills must be called in before 3:00 p.m. on Wednesday in order to be picked up on Thursday of the same week. Anything called in after 3:00 p.m. Wednesday on the pharmacy line will no be filled until the next week. We **DO NOT DO ANY Auto Refills.**
- ☐ Prescription refills are available for pick up on Thursday after 1:00 p.m. until 4:30 p.m. Next available pick up day for refills is Monday. Bernard Healthcare Center/Free Clinic of Franklin County is open Monday through Thursday 8:00 a.m. through 4:30 p.m. We close each day from 12:00 p.m. through 1:00 p.m.
- ☐ Bernard Healthcare Center/Free Clinic of Franklin County does not provide second opinions.
- ☐ Bernard Healthcare Center/Free Clinic of Franklin County does not assume responsibility for charges incurred at a Specialist office or for certain special diagnostics. It is Patient responsibility to inquire about possible fees prior to seeing the physician/specialist.
- ☐ Patients who are diabetic 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 by calling (540) 489-7500. Please clearly leave your name, phone number and appointment date and time. If you miss 3 appointments without calling, you will be seen only in walk in clinic.

Donations: Bernard Healthcare Center/Free Clinic of Franklin County depends on volunteers for their help. We depend on donations from the community in order to provide you with services. We ask that, when possible, make a donation to help keep Bernard Healthcare Center/Free Clinic of Franklin County going for you.
***Any amount is always appreciated. ***

Patient Signature: _____ **Date:** _____

Eligibility Screener: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this Notice which describes the health information privacy practices of Bernard Healthcare Center. A copy of our current Notice will always be posted in our reception area. You will also be able to obtain your own copy by calling the clinic at 540-489-7500 or asking for one at the time of your next visit.

If you have any questions about this Notice or would like further information, please contact the Executive Director at Bernard Healthcare Center.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient or receiving treatment or other health-related services from us;
- information about your health condition (such as a disease you may have).
- information about health care products or services you have received or may receive in the future; or
- information about your health care benefits under an insurance plan;

when combined with:

- demographic information (such as your name, address, or insurance status).
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); or
- other types of information that may identify who you are.

REQUIREMENT FOR WRITTEN AUTHORIZATION

We will obtain your written authorization before using your health information or sharing it with others outside Bernard Healthcare Center, except as we describe in this Notice. Uses and disclosures of health information that require your written authorization include: most uses and disclosures of psychotherapy notes, most uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information. Other uses and disclosures not described in this Notice or otherwise permitted by HIPAA will be made only with your written authorization. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the Executive Director at Bernard Healthcare Center.

3. **Emergencies or Public Need.**

As Required By Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if Notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under law, such as controlling disease or public health hazards. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so. We may also release your health information to government disease registries. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

Victims of Abuse, Neglect, or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our clinic. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair and Recall. We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure and only with a written certification by the party issuing the subpoena in accordance with law.

Law Enforcement. We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, or if necessary to report a crime that occurred on our property.

To Avert a Serious and Imminent Threat To Health or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person, or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security and Intelligence Activities or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

5. Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information.

1. Right To Inspect and Copy Records. You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the Executive Director at Bernard Healthcare Center. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide a written denial that explains our reasons for doing so, and a complete description of your rights to have that decision reviewed and how you can exercise those rights.

2. Right To Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records. To request an amendment, please contact the Executive Director at 540-489-7500. Your request should include the reasons why you think we should make the amendment. If we deny part or all of your request, we will provide a written Notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.

3. Right To an Accounting of Disclosures. You have a right to request an "accounting of disclosures," which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice. Many routine disclosures we make will not be included in this accounting; however, the accounting will include many non-routine disclosures.

To request an accounting of disclosures, please write to the Executive Director at Bernard Healthcare Center and indicate a time period within the past six years for the disclosures you want us to include. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period.

Free Clinic of Franklin County
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Bernard Healthcare Center

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Bernard Healthcare Center Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Bernard Healthcare Center providers and how I may obtain access to and control this information.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Bernard Healthcare Center/Free Clinic of Franklin County
www. bernardhealthcare.com

Sign one section please

MEDICAID/INSURANCE DISCLAIMER

I choose to continue receiving my primary healthcare from Bernard Healthcare Center.

I understand that Bernard Healthcare Center will not bill Medicaid or any other health insurance, and that any changes I incur will not be applied to my deductible.

I understand that I, or my insurance, will be responsible for paying for any laboratory testing, diagnostic testing, or referrals to specialist made from the center to outside providers.

I agree to pay a facility fee to Bernard Healthcare Center at the time of each visit.

Date: _____

Name: _____

Signature: _____

- ☐ $25.00 Facility Fee + Lab Fee (0 – 200 %)
- ☐ $35.00 Facility Fee + Lab Fee (201 – 300 %)
- ☐ $55.00 Facility Fee + Lab Fee (301 – 400 %)
- ☐ $75.00 Facility Fee + Lab Fee (401 – 500 %)
- ☐ $95.00 Facility Fee + Lab Fee

FREE CLINIC OF FRANKLIN COUNTY DISCLAIMER

Whenever possible I agree to pay a facility fee to Bernard Healthcare Center/ Free Clinic of Franklin County at the time of each visit.

Level 1 - <138 % of poverty
Level 2 – 139-200% of poverty
Level 3 – 201-300% of poverty

Date: _____

Name: _____

Signature: _____

- ☐ $5.00 Facility Fee + Lab Fee
- ☐ $10.00 Facility Fee + Lab Fee
- ☐ $15.00 Facility Fee + Lab Fee