Willing Helpers Medical

What paperwork should I bring to the intake?

- **Proof of identification (bring one)**
  - Driver's License or State ID
  - College ID
  - Passport

- **Proof of residency (bring one)**
  - Current telephone bill
  - Current gas bill
  - Current water bill
  - Current electric bill
  - If your name is not on any of the bills, you must bring a letter from the bill holder stating that you reside at the address listed

- **Proof of income or no income (bring one)**
  - Income Tax W2 Form or 1099 Form or last year's taxes
  - Payroll check stubs for the 30 days of work
  - Unemployment Eligibility Sheet, Checks or Check Stubs
  - Food Stamp Award Letter
  - Disability/Worker's Compensation Notification Form with your payment amount
  - Disability Notification Form with your payment amount
  - Official Documents from another Social Services Agency that lists your income
  - If you have not worked and have no income, go to the GA Department of Labor in Covington and ask for a copy of your "wage statement"

- **Letter of Support**
  - If you are supported by another person, please bring a letter, signed by them, that states what they help you with (a place to live, food, etc)

- **List of your monthly expenses**
  - This will help you complete your new patient paperwork

- **Your medical information (bring items these to EVERY visit)**
  - Any medicine bottles
  - Your blood sugar or blood pressure monitor if you have one
  - Any recent medical records/hospital records

WILLING HELPERS MEDICAL **NEW PATIENT INTAKE** **Date: _____ Pt Initials: _____**

Name: _____ Birth Date: _____ Age: _____ SSN: _____

Best phone number: _____ Email: _____

Address: _____

Emergency Contact/Relationship: _____ Number: _____

Why are you here today (what is your main medical problem?): _____

_____

What other doctors do you see: _____

Last time you saw a doctor: _____ Last time you were in hospital: _____ Why: _____

Preferred Pharmacy: _____

Have you applied for disability? Yes or No Details: _____ Have you applied for Medicaid: Yes or No

Employed: Yes or No Details: _____ Are you looking for work: Yes or No Are you a Veteran: Yes or No

Monthly Income (you AND any legally married spouse): _____

Household size (you, any legally married spouse, any children in your custody who live with you): _____

HOME ENVIRONMENT circle all answers that apply

Relationship status:	Single Partner Married Divorced Separated Widowed
Living arrangements:	House Apartment Mobile Home Homeless Other:
Lives with you:	Alone Partner Kids under 18 Family Friends Roommates Other:
Food	Have enough food Don't have enough food Have Food Stamps/SNAP Use food pantries
Transportation	I have a car that works No car/car broken I have people who can help I do NOT have help
Utilities	I have water and electricity where I live Do NOT have water and electricity where I live
Appliances	I have working stove/microwave & fridge Do NOT have working stove/microwave & fridge
Medicines	I usually spend _____ on my medications and medical supplies every month

SOCIAL HISTORY* circle all answers that apply *We only ask these questions to help us with your medical care

Spiritual/Religious?	Yes No	If yes, please know that prayer support is available at every visit if you are in need. Prayer is NEVER required to receive care. Ask at the check-in desk if interested.
Special needs?	Yes No	Reading Vision Hearing Mobility (wheelchair/walker, etc) Talking/Language Details:
Alcohol Use? **If yes, how often?**	Yes No	If YES, what kind of alcohol do you drink: Few Times a Year Few Times a Month Few Times a Week Every Day
Nicotine Use? **If yes, how often?**	Yes No	Cigarettes Cigars Snuff/Dip Snus Vape
Substances Use? **If yes, how often?**	Yes No	Marijuana Meth Cocaine Crack Heroin Other:
Use controlled meds not prescribed to you?	Yes No	Narcotics (like Percocet/OxyContin) Anti-anxiety (like Xanax/Klonopin)
Caffeine? **If yes, how often?**	Yes No	Coffee Tea Soda Energy Drinks Supplements
Exercise?	Yes No	Walking Running Aerobics Other:
Sleep?		Hours per night: Trouble Sleeping: Yes or No Snore: Yes or No

VACCINATIONS

Vaccine	Status	Date
Tetanus	Yes or No	
Hepatitis	Yes or No	
Pneumonia	Yes or No	
Flu	Yes or No	

ALLERGIES

Latex Allergy: Yes or No Shellfish or Iodine Allergy: Yes or No

Medication Allergies: _____

Food Allergies: _____

Environmental Allergies: _____

MEDICATION REVIEW

List any medications that you are taking, including vitamins, herbal, over-the-counter. Also, if you were told to take a medicine by a doctor but are not taking (can't afford, had side effects, took yourself off), please write those in last.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

MEDICAL PROBLEMS/HISTORY circle all answers that apply

General Health	No	Weight Loss Weight Gain Fever Chills Night Sweats
Diabetes	No	Type I (Childhood Diabetes) Type II (Adult Diabetes) Pregnancy Diabetes
		Pain or numbness in legs and feet Wounds on legs and feet Trouble digesting food Diet
Treatment:		Take pills Take Insulin Other: _____ Check blood sugar: _____ How Often: _____
Blood Pressure	No	High BP Low BP
Treatment:		Take pills Other: Check blood pressure: _____ How Often: _____
Heart	No	Chest Pain Palpitations Heart Failure Heart Attack How Many: _____ Murmur
Treatment:		Take pills to pee take other pills Daily weights Fluid Restriction Other:
High Cholesterol	No	High Cholesterol High LDL Low HDL High Triglycerides Other:
Treatment:		Take pills Other:
Blood Clots	No	Lung Clot Arm Clot Leg Clot Other:
Treatment:		Take Blood Thinner Pills Have a filter placed Other:
Lungs	No	Asthma Frequent Bronchitis COPD Emphysema Pneumonia
		Wheezing Cough Phlegm/Mucous Blood Snoring/Sleep Apnea Tuberculosis
Treatment:		Use nebulizer Use Inhalers Use Oxygen Use CPAP Use BiPAP
Stomach/GI	No	Reflux/heartburn Ulcers IBS Frequent diarrhea Frequent constipation
Treatment:		Frequent stomach/abdominal pain Blood in stool Black stool Polyps Other:
		Take pills Colonoscopy Other:
Kidneys/Liver/ Gallbladder	No	Blood in urine Leaking Urine Frequent Urine Feeling like bladder won't empty
		Frequent UTI Kidney Stones Gallstones Kidney disease Cirrhosis
Treatment:		Take pills Dialysis Other:
Acquired Disease	No	Hepatitis B Hepatitis C HIV AIDS Tuberculosis
Treatment:		Take pills Other:
Cancer	No	Skin Cancer Other Cancer:
Treatment:		Chemotherapy Radiation Take pills Other:
Mental Health	No	Depression Anxiety Panic Attacks Bipolar Schizophrenia Suicide Attempts Other:
Treatment:		Take pills Counseling Inpatient Treatment Do you see Viewpoint? _____
STI/STD	No	Trichomonas Gonorrhea Chlamydia Syphilis HPV/Genital Warts HSV Herpes
		Other:

Neurologic **Treatment:**	No	Stroke TIA/mini-stroke Seizure Migraines Frequent Headaches Severe dizziness Numbness/Tingling Fall out/pass out Take pills Other:
Ears/Nose/Throat	No	Hearing Loss Ringing in Ears Sore Throat Hoarseness Nosebleeds Seasonal Allergies False Teeth Seasonal Allergies Infections Pain Other:
Eyes	No	Glasses/Contacts Loss of Vision Double Vision Redness Pain Last eye exam: _____
Musculoskeletal **Treatment:**	No	Arthritis Swollen Joints Pain in: Neck Back Hips Legs Sciatica Bursitis Gout Take pills Physical Therapy Other:
Women's Health		**Last PAP smear: _____ Last Mammogram: _____** Last Period: _____ Do you do self-breast exams: Yes or No Any: breast lumps, skin changes, nipple discharge Birth Control Method: _____ Vaginal discharge Heavy periods Painful Periods Number of Pregnancies: _____ Vaginal births: _____ C/Sections: _____ Miscarriage/other: _____
Mens's Health **Treatment:**	No	**Last prostate exam: _____ Any family history prostate cancer: _____** Difficulty starting urination/weak stream Testicular pain/lumps Erectile Dysfunction Take pills Other:

SURGERIES/PROCEDURES

Surgery/Procedure	When	Results	Details
EKG			
Cardiac Stress Test			
Cardiac Cath			
Heart Stents			
Angioplasty			
Leg Artery Surgery			
Carotid Surgery			

Other Surgeries	When	Details

FAMILY MEDICAL HISTORY

Relative	Age	Diseases	Living?	Cause of Death
Father				
Mother				
Sister(s)				
Brother(s)				
Other				

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Willing Helpers Medical Clinic Patient Rights and Responsibilities

Patient **RIGHTS** include:

● The right to be treated with respect and dignity at all times.

● The right to ask questions, voice concerns, and participate in decisions regarding plan of treatment.

● The right to clear, concise explanations of techniques, procedural risks, possible outcomes, and probability of success.

● The right not to be subjected to any procedures without giving voluntary, competent, and understanding consent.

● The right to express feelings of discomfort about sharing medical issues to any staff member during clinic visits.

● The right to privacy and confidentiality regarding both personal and informational data as it pertains to healthcare.

● The right to have cultural, psychosocial, spiritual, and personal values, belief and preferences respected and be free from all forms of abuse, neglect, exploitation, or harassment.

Patient **RESPONSIBILITIES** include:

● The responsibility to complete clinic enrollment application before receiving medical treatment

● The responsibility to provide advance notification if unable to keep scheduled appointment at the clinic OR at a specialist office that you were referred to by the clinic. Appointments should be cancelled no later than noon the day before appointment.

● The responsibility to inform clinic staff of changes to contact information (address, phone number, income, insurance coverage) in a timely manner.

● The responsibility to provide a complete report of all medications that he or she is taking at the time of each clinic visit, including strength, dosage, and frequency. (Bring all medication bottles to each visit).

● The responsibility to notify the clinic at least one week prior to needing refills on medications

● The responsibility to comply with all clinic policies and procedures.

● The responsibility to comply with the treatment regimen.

● The responsibility to follow through with diagnostic tests, procedures within prescribed time frame.

● The responsibility to refrain from abusive language and behavior.

● The responsibility to report unexpected changes in medical condition to the practitioner.

Failure to comply with any of the above could result in loss of clinic privileges. Noncompliance will be documented in a patient's chart and will be reviewed by Clinic Manager and/or Executive Director after three noncompliance entries.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Willing Helpers Medical Clinic Appointment Cancellation/No-Show/Late Arrival Policy

Thank you for trusting your medical care to Willing Helpers Medical Clinic.

When you schedule an appointment with Willing Helpers Medical Clinic, we set aside enough time to provide you with the highest quality care.

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

If you will be more than 15 minutes late for an appointment, please contact the office to notify us and ensure that you can still be seen that day.

Please see our Appointment Cancellation / No-Show Policy below:

● Effective May 1, 2019, a note will be made in the chart of any established or new patient who fails to show or cancels / reschedules an appointment without at least a 24 hour notice.

● Any established or new patient who fails to show or cancels/reschedules an appointment without 24 hour notice for the third time in a rolling year will be dismissed from Willing Helpers Medical Clinic and will not be rescheduled.

● Any established or new patient who is more than 15 minutes late for a scheduled appointment for the third time in a rolling year will be dismissed from Willing Helpers Medical Clinic and will not be rescheduled.

● Willing Helpers Medical Clinic does attempt to remind patients of their visits by phone or email. **However, even if you do not receive a reminder call or message, the above Policy will remain in effect.**

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment.

If you should experience extenuating circumstances, please contact the clinic as soon as possible. You may leave messages with Willing Helpers Medical Clinic 24 hours a day, 7 days a week at 678-625-8317 or at info@willinghelpersclinic.com.

I have read and understand the Medical Appointment Cancellation / No-Show Policy and agree to its terms.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Willing Helpers Medical Clinic Contact Preferences and Receipt of Privacy Practices

Please answer the following questions about your privacy preferences and update the clinic if this information changes:

MESSAGE PREFERENCES

APPOINTMENT REMINDERS: May we leave voicemail, email, or text messages regarding your clinic appointments?

VOICEMAIL: YES ☐ NO ☐

EMAIL: YES ☐ NO ☐

TEXT MESSAGE: YES ☐ NO ☐

MEDICAL AND HEALTH INFORMATION: May we leave voicemail, email, or text messages regarding your health and medical information, including, but not limited to, test results, prescription information and recommendations?

VOICEMAIL: YES ☐ NO ☐

EMAIL: YES ☐ NO ☐

TEXT MESSAGE: YES ☐ NO ☐

FAMILY AND FRIENDS

FAMILY AND FRIENDS: May we discuss your general medical information with your family and friends?

YES ☐ NO ☐ SPECIFIC PEOPLE ONLY (please list below) ☐

Specific family and friends that Willing Helpers may discuss my medical care with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Willing Helpers Medical notice of privacy practices:

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Willing Helpers Medical Clinic
4186 Mill Street, Covington, GA 30016
Phone: 678-625-8317 Fax: 678-625-5131
www.willinghelpersclinic.com

Health Information Release Form/Medical Records Request

Patient Name: _____ **Date of Birth:** _____ **Last 4 of SSN:** _____

Where are records being requested from: _____

What approximate dates of service are needed: _____

Why are the records needed: ☐ Treatment ☐ Other: _____

What records are needed (check all that apply): ☐ Complete Record ☐Imaging Disk

☐Discharge Summary ☐History and Physical ☐Consults ☐Progress Notes

☐Operative Notes ☐Lab Results ☐ Pathology ☐Radiology Reports

☐ Other: _____

_____

Please EXCLUDE the following categories if checked:

☐Substance Abuse, if any ☐AIDS/HIV/STDs, if any ☐Psychological/Psychiatric conditions, if any

Please release the requested records to: ☐ Willing Helpers Medical Clinic

☐Other: _____

By signing this form, I authorize you to release my protected health information to the entity listed above.

Authorizing Signature: _____ **Date:** _____

Relation to patient: ☐Self ☐ Other (Name/Relationship): _____