Hope Clinic, Inc.

Self-Pay Income Verification Form

Thank you for choosing the Hope Clinic for your medical needs. Self-pay patients are expected to pay a down payment of at least $50.00 at check in before the office visit. The remaining balance for the office visit can have a payment plan arranged for future dates. LABS MUST BE PAID FOR AT THE TIME SERVICE. Hope Clinic, Inc. provides a standard Self Pay Rate as well as a Sliding Scale Fee Schedule for patients who are uninsured or who desire to be seen as a self-pay patient with NO insurance being filed. In order to qualify for the sliding scale fees, you will need one of the following documents to determine your cost for service:

- 2 consecutive months' Pay Stubs
- Most recent W-2 Form
- Statement from employer verifying income
- Shelter letter
- Treatment Program letter
- Letter From Case Worker
- Letter From Church or other Help Center
- Notarized letter stating how daily needs are met explaining financial situation, housing, food, daily living costs, etc.

If you do not supply proper documentations, or if your income does not qualify for the sliding scale fees, you will be charged at the Hope Clinic Self Pay Rate of 30% off standard rates.

If you do not have proper documentation, but do qualify for sliding scale fees. You will receive a 1 time sliding scale discount. You will be required to provide documentation as soon as possible in order to receive any additional sliding scale discounts.

The Self Pay/Sliding Scale parameters have been evaluated against an income scale published annually by the Federal Government Register (http://aspe.hhs.gov/poverty/15fedreg.htm) and make you eligible to receive a discount for medical care services provided by the Hope Clinic. I acknowledge that only those services provided directly by Hope Clinic, Inc. are considered eligible for discount. Any care received outside of the Hope Clinic, even if you are referred by a Hope Clinic physician, are not subject to the discount. Your Hope Clinic provider has the option to further discount any self-pay rates at his/her discretion.

I understand that the Self Pay/Sliding Scale rates will be applied to my charges and all payments **must be paid at the time of service**. I understand that I may be denied services in the future if I do not meet required payments in accord with my ability to pay. I also understand that the Self Pay/Sliding Scale discount will be applied to all services received for the remaining calendar year period at which my income and family status will be re-evaluated.

I have read the above statements or had them read to me and I agree to be a patient under the care of the Hope Clinic under these financial conditions.

Hope Clinic, Inc.
Notice of Privacy Practices

Rev.2.16.2013

THIS 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.

Hope Clinic, Inc. and its affiliated physicians or providers make a record each time you receive health care or services. Your records have information about your symptoms, examination, test results, diagnosis and billing for services. The law requires Hope Clinic to keep your health information private and also to tell you about how it keeps health information private. Hope Clinic, Inc. is required to abide by the terms of the Notice of Privacy Practices (NPP) currently in effect. You can always request a copy of this Notice from our Registration area.

HOW WE MAY USE AND DISCLOSE (RELEASE) HEALTH INFORMATION ABOUT YOU

Use means sharing health information inside Hope Clinic. Disclosure means release of health information outside Hope Clinic. We may use and disclose health information in the following ways without getting specific permission.

- **Treatment, Payment, Health Care Operations**

• **Treatment** – to provide, coordinate or manage your health care and related services. Doctors, nurses, technicians, medical students and others involved in taking care of you share medical information about you. Your treatment includes working with people involved in your care before and after your Hope Clinic services. For example, Hope Clinic may disclose information to (1) an ambulance service that takes you from Hope Clinic; (2) a rehabilitation center or home health agency that will be caring for you; and (3) other doctors who may be treating you, such as the doctor who referred you to Hope Clinic or to whom a Hope Clinic provider refers you or who is otherwise involved in your care.

• **Payment** for Treatment – to help Hope Clinic or another provider obtain payment for your health care services. Payment activities include (1) checking eligibility or referral from a health plan; (2) reviewing need for and use of services; and (3) sending bills to you or your insurance company.

• **Health Care Operations** – to help run Hope Clinic or to check the quality of care that you receive. For example we may combine information from multiple sources about patients to review their care. We may also use health information to review employees' performance; train students; help meet licensing and accreditation rules; and market and raise funds for Hope Clinic. We may disclose your health information to "Business Associates" that we hire to help us, such as billing and computer companies, accountants, and typists. All Business Associations must assure us in writing that they will safeguard your health information.

- **Other Permitted Uses and Disclosures**

Hope Clinic may also use and disclose your
Health information for the following:

• **Appointment Reminders**: sent to you about medical treatment or care.

• **Health-Related Benefits and Services and Treatment Alternatives:** sending information about treatment alternatives or other health-related benefits and services that may interest you.

• **Fundraising Activities:** contacting you about Hope Clinic fundraising efforts. Any materials received will contain information on how to remove yourself from the fundraising list.

USES AND DISCLOSURES REQUIRING AN OPPORTUNITY TO AGREE OR OBJECT

For the following uses and disclosures of health information we must provide an opportunity for you to agree or object:

Persons Involved in Your Care

• To people involved in your care or in payment for your care such as family members, relatives, close friends or other persons you identify.

• When you are not present we may use professional judgment and your best interests and decide to disclose relevant information to an individual who is directly involved in your health care.

Notification

• To notify your family or other person responsible for your care of your location, general condition, or death.

Disaster Relief Purposes

• To authorized public or private entities to assist in disaster relief efforts.

• To coordinate uses and disclosures to individuals involved in your care.

USES OR DISCLOSURES THAT DO NOT REQUIRE YOUR PERMISSION

Hope Clinic may use or disclose your protected health information in some cases without your authorization. The following list describes the ways this may happen. Not every use or disclosure in a category will be listed. But we provide a brief description in certain cases.

• **As required by law**

• **For Public Health Activities**: to prevent or control disease, injury, or disability; to report child abuse or neglect; or as otherwise authorized by law; to report reactions to medicine or problems with products; to notify a person exposed to a contagious disease.

• To **prevent a serious threat** to health or safety.

• To **your employer for evaluation** of work related illness or injury, or for medical surveillance purposes.

• For **Lawsuits and Administrative Proceedings**: To respond to court or administrative order; to respond to a subpoena or lawful request.

• Request confidential communications of protected health information in a certain way or at a certain place.

All requests must be made in writing. If we accept your request, we will require you to provide information about payment handling, alternate address, and contact method.

• For **law enforcement purposes**: To respond to a warrant, identify suspects, or to report crime on Hope Clinic property.
• **To report suspected abuse and neglect** of the elderly, disabled, or nursing home patients to appropriate government agencies.
• To comply with laws relating to **Workers' Compensation** or other similar programs.
• **To correctional institution or law enforcement**, if you are an inmate of a correctional institution or in law enforcement custody, to provide you with health care; to protect the health and safety of yourself or others; for health and safety of a correctional institution.
• **To Coroners and Medical Examiners**: To identify, determine cause of death or perform other duties.
• **To Funeral Directors** to carry out their duties.
• **Organ and Tissue Donation**: To organizations that handle organ, eye, or tissue donation and transplants.
• **To Health Oversight Agencies** for activities such as audits or inspections to oversee the health care system or government programs
• **Research uses and disclosures permitted without authorization:** Reviews of information to prepare research; research on dead person's information; or research use or disclosure with an approved waiver of authorization. Such waivers require special review and approval.
• **Special Government Activities**
– Military Activities: To appropriate military command authorities as required, if you are U.S. armed forces personnel; and for foreign military personnel, to appropriate foreign military authorities.
– To authorize federal officials for lawful national security purposes, to provide protective services for the President and others.

USES AND DISCLOSURES THAT REQUIRE WRITTEN AUTHORIZATION

Other uses or disclosures of your record will be made only with your written authorization. Disclosures requiring written authorization include drug and alcohol treatment records, mental health records, and AIDS/HIV and genetic testing information. You may withdraw an authorization at any time; however, we are not able to take back disclosures that we have already made with your authorization. Also, you cannot withdraw an authorization that was a condition of obtaining insurance coverage. All withdrawals must be made in writing. Contact the Hope Clinic privacy officer (770) 685-1300.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Regarding medical information we maintain about you, you have the right to:
• Request restrictions on uses and disclosures of your record for treatment, payment or health care operations. All requests must be made in writing. The law does not require us to agree to restriction requests. For emergency treatment, we may use or disclose restricted information. The right to request restrictions does not apply to uses and disclosures required by law.
• inspect and copy protected health information that may be used to make decisions about you. This does not include psychotherapy notes, clinical laboratory data or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding. This right is suspended temporarily until study completion for information created or obtained during research. The law permits us to charge a fee for copying costs.
• request us to amend information that may be used to make decisions about you. We are not required to agree to your request. We may deny your request if: (1) Hope Clinic did not create the information, unless the person or entity that created the information is no longer available to make the amendment; (2) the information is not part of the information kept by or for Hope Clinic to make decisions about you; (3) the information is not part of the information that you are allowed to inspect or copy; or (4) the information is complete and accurate. You must request an amendment in writing and supply a reason to support your request.
• receive an accounting of certain disclosures of your protected health information. The accounting right does not apply to disclosures that you have authorized or to disclosures for treatment, payment, and health care operations.
• obtain a paper copy of this Notice upon request.

HOW TO EXERCISE THESE RIGHTS OR GET MORE INFORMATION ABOUT THIS NOTICE

To exercise your rights or for more information about matters in this Notice, please contact:
Hope Clinic Privacy Officer
Hope Clinic, Inc.
121 Langley Drive
Lawrenceville, GA 30046
(770) 685-1300 Fax: (770) 685-1311

HOW TO FILE A COMPLAINT

If you believe your privacy rights have been violated or to file a complaint, please call the **Privacy Officer at (770) 685-1300.**
You may also file a complaint with the Secretary of the Department of Health and Human Services in Washington, D.C.
Hope Clinic will in no way retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as for any information we receive in the future. We will post a copy of the current Notice in the Clinic. If we change the NPP, you will get a new NPP at your next visit to Hope Clinic after the change takes effect.

Hope Clinic, Inc.

PATIENT TREATMENT CONTRACT

As a patient receiving medical care from Hope Clinic, Inc., I freely and voluntarily agree to accept this treatment contract as follows:

1. I must keep and be on time to all of my scheduled appointments. I will be charged for all missed appointments, or cancellations made within 24 hours of my appointment.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the office to ALL staff.
4. I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a violation of this agreement, and may result in my treatment being terminated.
5. I agree that my medication/prescription can only be given to me at my regular office visits. I will be prescribed enough refills to last until my next office visit. A missed visit may result in my not being able to get my medication until my next office visit.
6. I understand that refill requests by phone will NOT be accepted.
7. I agree the medication/prescription I receive is my responsibility, and I agree to keep it in a safe and secure place.
8. I understand Hope Clinic providers will not refill prescriptions that have been lost or misplaced, please do not ask.
9. I agree not to obtain any narcotics or controlled substances from any other physician without notifying my treating provider. This is grounds for immediate termination from Hope Clinic, Inc. practice.
10. I agree to take my medication as instructed by my doctor, and I will not alter the dose or time interval without consulting with my physician first.
11. I understand that Hope Clinic providers do not prescribe narcotic pain medication for chronic pain management. Treatment for chronic pain will be referred to a pain clinic.
12. I understand that if I cannot afford my medications, I can apply for patient assistance at a small cost. Patient assistance applications are available at the front desk.
13. I understand that it can take up to 1 month for patient assistance applications to be processed.
14. I understand that an office visit is required for test or lab results.
15. I understand that there is a fee for any letters or special correspondence that the physician prepares, as well as for medical records.
16. I understand that violating any of the above may be grounds for termination from this practice.
17. It is the policy of this office that payments are made at the time of your visit. I understand that regardless of my insurance status, I am ultimately responsible for payment of services which is due at the time of your visit.

I have read, understand, and agree to the above policies. I understand that violations of the above policies may result in my termination of treatment.

121 Langley Drive, Lawrenceville, GA 30046
770-685-1300

Last Name	First Name	M.I.	Date of Birth

Gender: ☐ Female ☐ Male

Hispanic: ☐ Yes ☐ No

Race: (Check all that apply)

☐ White ☐ American Indian/Alaska Native

☐ Black/African-American ☐ Hawaiian/Other Pacific Islander

☐ Asian

Do you live is a Female-Headed Household? ☐ Yes ☐ No

Household Income:

Household income includes wages, salaries, tips, self-employment or business income, unemployment & disability income, SSI, income from assets, retirement & insurance income, public assistance, interest & dividend income, alimony, child support, gift income, and armed forces income for all family members 18 years of age or older.

$_____ ☐ Monthly ☐ Yearly _____

Household Income **# of Household Occupants**

Certification: (Please read before signing)

Hope Clinic, Inc. is supported with Federal funding. According to Title 18, Section 1001 of the U.S. Code, it is a felony for any person to knowingly and willingly make a false or fraudulent statement to any department of the United States Government. By signing this document, I verify under the penalty of perjury, that all the information on this application is correct to the best of my knowledge and belief, and I acknowledge that such information is subject to verification. I also acknowledge that falsification of this information shall be grounds for my termination from the program, repayment of all Federal funds received and/or prosecution under the law. I authorize the release of this information to local, State and/or Federal agencies, and to Gwinnett County staff within five years of this date.

_____ _____

Patient / Guarantor Signature **Date**

2018

Hope Clinic, Inc. Registration Form

(Please Print)

First Name _____ Middle Initial _____ Last Name _____

Nickname _____ ☐ Female ☐ Male Primary Language _____

Address _____ City _____ State _____ Zip Code _____

County _____ Social Security # _____ Date of Birth _____ Marital Status _____

Phone #1 _____ ☐ home ☐ cell ☐ work ☐ other Employer Name _____

Phone #2 _____ ☐ home ☐ cell ☐ work ☐ other Employer Address _____

Phone #3 _____ ☐ home ☐ cell ☐ work ☐ other City/State/Zip _____

Email Address _____ Primary Language _____

Primary Provider _____ Referring Provider _____

Race: (Check all that apply)

☐ White ☐ American Indian/Alaskan Native **Ethnicity: Hispanic :** ☐ **Yes** ☐ **No**

☐ Black ☐ Hawaiian/Other Pacific Islander

☐ Asian **Referral Source: (How did you hear about us)?** _____

Guarantor/Responsible Party ☐ Same as Patient

If not the patient, the section below must be completed and signed by the responsible party

First Name _____ Initial _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home Phone # Cell Phone # Social Security #

Guarantor Signature: Relationship to Patient:

Insurance Information: (enter all information **as it appears on the card**)

Insurance Name _____ Policy Holder's Name _____

ID # / Policy # _____ Group # _____

Policy Holder's SS# _____ Policy Holder's Date of Birth _____

Policy Holder Address _____ Relationship to Patient _____

Emergency Contact Information:

Name _____ Phone # _____ Relationship to Patient _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand and agree that regardless of any insurance status, I am financially responsible for any professional services rendered. I also authorize Hope Clinic, Inc. to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____

HOPE CLINIC INC.
121 LANGLEY DRIVE
LAWRENCEVILLE, GA 30046
(770) 685-1300

HIPAA PRIVACY FORM

You have permission to confirm my appointments (please check all boxes that apply)

□ Leaving message at home with _____ **(please indicate relationship)**

□ Leaving message at work **number** _____

□ Leaving a message on voicemail **number** _____

□ Leaving a message on my answering machine **number** _____

□ Do not confirm my appointment; **I will contact you.**

We may discuss your medical condition with:

□ Husband/Wife: name: _____ phone number: _____

□ Mother/Father: name: _____ phone number: _____

□ Son/Daughter: name: _____ phone number: _____

□ Sister/Brother: name: _____ phone number: _____

□ Other: name: _____ phone number: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read or received the following forms. These forms describe how my health information may be used or disclosed, and the current policies of Hope Clinic, Inc.

_____ **Notice of Privacy Practices (HIPAA)**
Initial

_____ **Patient Treatment Contract**
Initial

_____ **Self-Pay Income Verification** □ **Not Applicable**
Initial

_____ ____/____/____
(Please Print your Full Name) Date of Birth

_____ ____/____/____
SIGNATURE Date

Rev. 8/2016

Original Date:
Dates Revised:

HopeClinic

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Hospitalizations		
Year	Reason	Hospital

FAMILY HEALTH HISTORY (INCLUDE ANY CARDIAC OR STROKE, AND AGE OF ONSET)

	AGE	Significant Health Problems		AGE	Significant Health Problems
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling(s)	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Please turn to next page

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)		
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		

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

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Patient Health Questionnaire – PHQ-9

Patient Name _____ **DOB** _____ **Today's Date** _____

1. **Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals	0			

2. **If you checked off any problem on this questionnaire so far, how difficult have these 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
0	1	2	3

Hope Clinic, Inc.
121 Langley Dr. Lawrenceville, GA 30046

Hope Clinic, Inc.

Narcotic Prescription Policy

Hope Clinic, Inc. would like to inform you that our providers do not prescribe narcotic pain medication for chronic pain management. If you take pain medications for chronic plan in a daily basis, you will be referred to a pain clinic.

Please sign and date below stating you have read and understand this notice.

Thank you.

Patient Name	Date of Birth
Patient Signature	Date

121 Langley Drive, Lawrenceville, GA 30046
770-685-1300 ~ 770-685-1311 (fax)