

Marian Clinic Patient Registration

Date/Fecha _____ Name/Nombre _____

Last Name/Apellido _____ **First Name/Nombre** _____ **MI** _____

Have you every been a patient before? Yes__No__ / ¿Ha sido usted paciente anteriormente? Yes__No__

If so, when? _____ / ¿Si es asi cuando? _____

Birthdate/Nacimiento _____ Age/Edad _____ SS#/Seguro Social _____

Address/Dirección _____ Apt# _____ City/Ciudad _____

County/Condado _____ State/Estado _____ Zip Code/Zona postal _____

Employer/Patron _____ Occupation/Ocupación _____

Home phone/Teléfono _____ Work phone/Teléfono del trabajo _____

If married, name of spouse/¿Casado(a)? nombre de su esposo(a) _____

Employer/Patron _____ Occupation/Ocupación _____

Health Care/Aseguranza: Private Health Insurance/Seguro Medico Privado _____ Medicare _____

Medicaid _____ Veteran's Benefits/Veterano(a) _____ Other/otra _____ I have no Health Insurance _____

No tengo aseguranza _____ Is it possible you will receive Medicare, Medicaid or Health Insurance?

Es posible que usted reciba Medicare, Medicaid o Seguro Medico? Yes _____ No _____

If yes, please explain / Si la respuesta es sí, explique _____

If injured, did this injury happen at work? / ¿ Es ésta una herida debido a su trabajo? Yes _____ No _____

Were you injured in a car accident? / ¿Es una herida por accidente de auto? Yes _____ No _____

Do you receive any type of disability benefits?/Recibe beneficios por incapacidad Yes _____ No _____

For Women only: Are you the major wage earner in your household? Yes _____ No _____

Para Mujeres: Es usted el principal ingreso de la familia en su hogar? Yes _____ No _____

In case of emergency, please contact / En caso de emergencia contactar a:

Name/Nombre _____ Relation/Relación _____

Work phone?Teléfono del trabajo _____ Home phone/Tel. Casa _____

U.S. Citizen/Ciudadano Americano? Yes _____ No _____ First language/Primer Idioma _____

If patient is a minor father's/mother's name/Si el paciente es menor de edad nombre de la mamá/papá _____

Address/dirección _____

Phone(if different)/ Teléfono (si es diferente) _____ Other language _____

For statistical purposes only, check / para estadísticas únicamente por favor marque:

Sex / Sexo: M _____ F _____ **Ethnicity / Raíz:** Hispanic or Latino _____ not Hispanic or Latino _____

Race: White _____ African American _____ Asian _____ Pakistan _____ Other _____

American Indian _____ Enrolled in federal recognized tribe? Yes _____ No _____

Name of tribe _____

Marital Status/Estado Civil:

Single/soltero _____ Married/casado(a) _____ Divorced/divorciado(a) _____ Widowed/Viudo(a) _____ Separated/Separdo _____

Housing/Hogar:

Own/Dueño(a) _____ Rent/Renta _____ Homeless/Sin hogar _____ Living with friends/family/vive con familiares _____

Shelter/Otro _____

Employment/Empleo:

Employed/Trabaja _____ Unemployed/No trabaja _____ Student/Estudiante _____ Retired/Jubilado(a) _____

If unemployed, when were you last employed?/¿Si está desempleado cuándo fue su último empleo? _____

Please list all sources of GROSS income for the past 4 weeks(before taxes) for patient's household:
 Declare todos los ingresos de las últimas 4 semanas de su hogar (antes de impuestos) :

Circle all that apply / Marque con circulo	Name/Nombre	Amt/Suma	How often? ¿Cada?
Household Paychecks / Ingreso familiar			
Household Paychecks / Ingreso familiar			
Tips / Propinas			
TAF			
Child Support / Soporte de Divorcio			
Alimony / Pensión Alimenticia			
Unemployment /Desempleo			
Worker's compensation/ compensación			
Pension / Pensión			
Social Security			
SRS / Cash Assistance/ Asistencia/Ayuda			
Other income / Otros ingresos			

How many people does this support? / ¿Para cuantas personas de la familia son estos ingresos?_____

Please list all members of your household starting with the patient:

Haga una lista de todos los miembros de la familia empezando por el paciente:

Name	Date of Birth	Age	Sex	Relationship to patient
Nombre	Nacimiento	Edad	Sexo	Relación con el paciente
				SELF / YO MISMO

This information is complete and correct and I provide it in order to receive care under the Charitable Health Care Provider Program(K.S.A. 75-6120). If Marian Clinic finds that you have intentionally given false financial information, you will be denied services.

Esta información que he dado es completa y correcta, para recibir servicios bajo el Programa de Caridad del Cuidado de la Salud (K.S.A. 75-6120). Si Marian Clinic encuentra que usted intencionalmente ha dado falsa información financiera, se le negarán los servicios.

Patient Signature/ Firma _____ Date/Fecha _____

\$=H&E	Tracking	Ini.
A B C	30 50 80 Women's Health Only Yes___ No___	



PATIENT RESPONSIBILITIES FORM

Program overview

Doctors, area clinics, pharmacists, hospitals and many others are donating their services to help you get well and stay well. They are not being paid for the services provided to you. This is not a government program, nor an entitlement program. The donated care may end at any time, for any reason. HealthAccess does not include emergency room expenses or ambulance services. By signing this form you authorize HealthAccess to verify what you have reported during the application process, if you have provided false information that makes you ineligible for HealthAccess, you may be financially responsible for the donated care you received. You may also receive some bills, for which you are responsible, should you need services not currently being donated for the HealthAccess program.

General

You agree that you:

1. Will not schedule appointments with any doctor, clinic or hospital other than the ones to which you have been referred.
2. Will follow your treatment plan, for example: get prescribed medicines and take as directed.
3. Will promptly supply any information which may be requested by the program within the time frame requested.
4. Will allow all information regarding your participation in this program to be shared with other individuals, organizations and agencies at the discretion of SCMS HealthAccess in accordance with state and federal laws.
5. Will immediately contact your enrollment site or SCMS HealthAccess if your income changes or you become covered by Medicare, Medicaid, private insurance, other health insurance or medical benefits.
6. Will apply for Medicaid, Healthwave or other assistance programs if and when you are eligible.
7. Will authorize the State Department of Social and Rehabilitation Services to share information regarding your eligibility for Medicaid and other SRS programs with SCMS HealthAccess staff and with SCMS HealthAccess medical providers.
8. Will contact SCMS HealthAccess immediately with any changes in address or phone number.

Referrals

You agree to:

1. Keep each doctor's appointment. (if you miss 3 or more appointments in 12 months without letting the doctor's office know at least 24 hours before your appointment, you will be disenrolled from the program.)
2. If you are unable to keep an appointment, you are responsible for notifying the doctor's office with whom you are scheduled, at least **24 hours in advance** to cancel and reschedule the appointment.
3. Present your SCMS HealthAccess Patient I.D. card each time you see a doctor.
4. Call your enrollment site or SCMS HealthAccess doctor if you need to be seen anywhere else for care.

Medications Assistance

You understand that:

1. There is a 12 month maximum coverage of \$750, and a maximum cost of \$200 per prescription, unless funds are available and preauthorized by SCMS HealthAccess.
2. Most Generic medications are available through this program. Your physician may be contacted and asked to use medications which are covered by the program.
3. A pharmacy may stop participating at any time, for any reason.
4. A co-pay per prescription will be required by your pharmacy.
5. You are to present your medication card each time you have a prescription filled.

Please Note

- HealthAccess will not discriminate based on race, religion, color, sex, disability, age, national origin or ancestry, or in any other manner as described in state and federal guidelines.
- HealthAccess does not provide medical care or services and does not make decisions regarding medical treatment plans. Those decisions remain between the providers and patients.
- All voluntary providers are independent contractors; they are not considered agents or employees of HealthAccess.
- HealthAccess is not responsible for bodily injury or negative outcomes potentially experienced within the provision of services by voluntary care providers. HealthAccess cannot guarantee the skill, care or training of voluntary providers.

By signing this form you confirm that you understand and agree to the above conditions and that the income information you provided is accurate. If you do not follow the above guidelines, you will be disenrolled from SCMS HealthAccess. Applicant Signature and Date (or Signature of Mother or Father of Applicant if Minor is under 18):

Signature

Date



Authorization Allowing Disclosure of Protected Health Information

I hereby authorize all health care providers providing services or treatment to me through the Shawnee County Medical Society Foundation Inc.'s HealthAccess Program to disclose information regarding all medical treatment regardless of format, *e.g.*, written, verbal, or electronic in the possession of such health care provider (hereinafter "office/hospital") to Shawnee County Medical Society and Shawnee County Medical Society Foundation, Inc., and to their agents, representatives, and employees, including, but not limited to, Blue Cross and Blue Shield of Kansas, Inc., the Kansas Department of Social and Rehabilitation Services, and their agents, representatives, and employees to manage, operate, and evaluate the HealthAccess Program.

The Authorization will expire on my disenrollment from the HealthAccess Program.

I understand I have the right to revoke the Authorization by delivering such revocation in writing to the office/hospital. I understand Shawnee County Medical Society Foundation, Inc. may terminate my participation in the HealthAccess Program if I revoke this Authorization.

Once the uses and disclosures have been made pursuant to this Authorization, they may be subject to redisclosure by any recipient and no longer protected by the federal privacy laws.

Office/Hospital will not condition treatment on my providing authorization for this use or disclosure. I understand, however, that the HealthAccess Program requires this signed Authorization prior to my being allowed to participate in the HealthAccess Program.

I understand that I may inspect or copy the protected health information to be used or disclosed under this Authorization. I understand I may refuse to sign the Authorization but that if I refuse to sign this Authorization, I may not be allowed to participate in the HealthAccess Program.

I understand that I will receive a copy of this Authorization.

Applicant Signature (if Patient is a Minor Under 18 years, the Name of the Minor is Necessary)

Applicant Signature (or Signature of Mother or Father or Personal Representative of Applicant if Minor is Under 18)

Description of Representatives Authority to Act for Patient

Date: _____

MARIAN CLINIC

healthier lives for the uninsured

1001 SW Garfield Avenue Topeka KS 66604 785-233-8081

Marian Clinic is a health care facility for any Shawnee County resident who has no health insurance or medical card and who meets the Clinic's income guidelines. All physicians and nurses at the Clinic are licensed in the state of Kansas. Many volunteers donate their services to help you. Occasionally a patient may have medical needs that are beyond the scope of the Clinic to help with, in which case you will be informed. Examples would be ambulance service and equipment and supplies you obtain elsewhere.

Patient Rights

You have the right to:

- Be fully informed, have reasonable access to our health care services and to understand your diagnosis and treatment plan and to participate in decision-making regarding your health care.
- Confidentiality and to be treated with respect at all times express a complaint and to receive an answer to your complaint within a reasonable amount of time.
- Ask questions, but please call Marian Clinic with questions, not the volunteer doctors in their offices.

Patient Responsibilities

You have the responsibility to:

- Follow the recommendations of your providers or assume the consequences and risks of not doing so.
- Treat Marian Clinic staff and other patients with respect.
- Call the Clinic or fill out a detailed medication refill form five days before you run out of the medication.
- Keep appointments, both at Marian Clinic and off site, and to cancel twenty-four hours ahead of time if you cannot make it to your appointment.
- Marian Clinic is not responsible for charges to patients, which are beyond its resources or scope of services. Cooperative hospitals, upon referral from a Marian Clinic volunteer physician, provide diagnostic and treatment services for Marian Clinic patients. I understand that I am expected to cooperate fully with the hospital and their designated legal aid services in seeking available state or government assistance and if I do not cooperate, the hospital charges will be incurred by me. Health care charges incurred prior to or outside of services directly ordered through Marian Clinic are my responsibility.
- Remind your off-site referral physician to confirm with Marian Clinic staff that additional referrals he or she makes are within the Marian Clinic network of volunteers.
- Notify Marian Clinic of changes in your address and/or phone numbers.
- Notify Marian Clinic immediately if you obtain health insurance or if your income level increases.
- Cooperate fully with health care institutions and legal aid services in seeking assistance.
- Update your eligibility as a Marian Clinic every 12 months or Health Access every six months.
- Pay your share of the services provided at the Marian Clinic.
- Pay for medical services not covered by Marian Clinic.

Permission to Treat

I give permission to:

- Be seen and treated by a Marian Clinic physician or other provider who agrees to accept Marian Clinic referrals.
- Allow Marian Clinic to release confidential information to health care providers who are involved in my care.
- **I acknowledge I have read and received a copy of this form.**

Patient Signature

Print your name

Date

Staff Signature

Date