103 Bonnie Drive,
Butler, PA 16002

www.butlerhealthclinic.org

p: 724-841-0980
f: 724-841-0984

info@butlerhealthclinic.org

JEAN B. PURVIS
COMMUNITY HEALTH CENTER

Application Date: _____ ☐**Medical** ☐**Dental** ☐**Behavioral Health** ☐**Vision** ☐**Derm**

PATIENT INFORMATION

LAST NAME: _____

FIRST NAME: _____

Middle Initial: _____

Former Last Name: _____

Sex at Birth: ☐ Female ☐ Male

Date of Birth: _____ /_____ /_____

SSN: _____-_____-_____

Address: _____

_____

Zip Code: _____

City: _____

State: _____

Phone Number: _____-_____-_____

Consent to Text: ☐Yes ☐No **(appt. reminders)**

*** Permission to leave a voice mail** ☐Yes ☐No

Email: _____

Do you have health insurance? ☐Yes ☐No

Do you have dental insurance? ☐Yes ☐No

Are you a Veteran? ☐Yes ☐No

*** The Community Health Center (CHC)**
IS NOT INSURANCE.
All services provided by CHC are FREE.
CHC is Volunteer-Powered and Community-Funded.

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone Number: _____-_____-_____

EMPLOYMENT INFORMATION

Employer Name: _____

Employer Phone: _____-_____-_____

Occupation: _____

Language: _____

Race/Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Latino/Hispanic ☐Middle Eastern ☐DTA ☐Native American ☐Other _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Partner ☐Separated ☐Widowed ☐DTA

Gender Identity: ☐Male ☐Female ☐Transgender ☐Gender Non-Conforming ☐Other_____ ☐DTA

Pronouns: ☐He / Him ☐She / Her ☐They / Them ☐DTA

US Citizen: ☐Yes ☐No **US Resident:** ☐Yes ☐No

Education: ☐Some High School ☐GED ☐High School Grad ☐Vocational ☐Some College ☐College Grad ☐DTA

Medicaid Status: ☐Pending (Date applied): _____ ☐Haven't Applied ☐Not Eligible-Non-Compliance ☐Not Eligible-Income ☐Not Eligible-Citizenship ☐Aetna ☐Highmark Wholecare ☐UPMC for You ☐United Healthcare

Transportation: ☐I have transportation ☐I do NOT have transportation

Employment Status: ☐Full Time ☐Part Time ☐Seasonal ☐Self-Employed ☐Retired ☐Disabled ☐Unemployed

How did you hear about us? ☐Butler Hospital ☐CCR ☐Church ☐Current/Former Patient ☐Dept. of Human Services ☐Family/Friends ☐Hospital (Other) ☐Online Search ☐Physician ☐Social Service Agency ☐Specialist ☐ TV/Radio ☐VA ☐Other: _____

***DTA (Decline to Answer)**

NAME: _____ **DATE OF BIRTH:** _____

INCOME VERIFICATION

CHC defines "household" as the applicant, spouse, and dependents.
If SINGLE, please indicate only your income and total children (if applicable) in the household.
If MARRIED, please indicate your and your spouse's income and total children (if applicable) in the household.

Total # in Household: _____

# of Adults: _____ **# of Children (under 18):** _____

$_____ **Total Household Monthly Income**

Did you file a tax return last year? ☐Yes ☐No **Tax return attached?** ☐Yes ☐No

* To request a copy of your tax return, complete IRS form 4506 or call 1-800-908-9946

Below, please identify all household members and all household income sources.

Name	Date of Birth	Source of Income *(employment, SSI, child support, unemployment, retirement, etc.)*	Amount *(monthly gross)*	Proof Attached
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

Why do I need to provide my pay stubs and tax returns? *These documents are **REQUIRED** to determine eligibility for services at the CHC and will be needed to acquire medications at a free or reduced cost. Many drug manufacturers have Prescription Assistance Programs (PAP).*
ALL the drug manufacturers who offer PAP REQUIRE income verification.

***Please sign only if indicated NO INCOME**

DECLARATION OF NO INCOME

I, _____ (print name), confirm the fact that I **DO NOT** and have **NOT** received any income in the past **THREE** months. This includes wages from employment or self-employment, alimony, cash assistance, child support, pension, social security, unemployment, and/or workers' compensation.

I certify that the information provided is complete and accurate to the best of my knowledge. I understand that the services the Community Health Center provides are based on income guidelines. I understand that upon employment or receipt of any income, I must submit proof of income to the Community Health Center.

Print Name _____Signature_____Date_____

NAME: _____ **DATE OF BIRTH**: _____

HISTORY AND PHYSICAL

Have you been in the hospital or emergency room in the past 12 months? ☐**Yes** ☐**No**

If yes, how many visits have you had in the past 12 months? _____

Do you live in an unsafe environment or have any fears for your physical safety? ☐**Yes** ☐**No**

Who was your previous primary care physician? _____ **Date last seen?** _____

Are you receiving behavioral health (counseling) services? ☐**Yes** ☐**No**

Name of Facility and Date last seen? _____ ____/_____/_____

LIST ALL CURRENT MEDICATIONS:

(including prescriptions, aspirin, vitamins, supplements, herbal remedies, and over-the-counter medications)

Please bring all current prescriptions to your initial medical appointment.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PREFERRED PHARMACY: _____

Allergies: _____

Do you have a Latex allergy? ☐Yes ☐No

Immunizations:

Flu Shot: _____ *(Year)* Tetanus: _____ *(Year)* Hepatitis B: _____ *(Year)*

Pneumonia: _____ *(Year)* TB Test: _____ *(Year)* Covid-19: _____ *(Year)*

Other? _____ *(Year)*

Social History:

	Current	**Former**	
Cigarette Use?	☐Yes ☐No	☐Yes ☐No	How many packs per day? _____
			How long have you smoked? _____
Chewing Tobacco/Snuff?	☐Yes ☐No	☐Yes ☐No	
Illicit Drugs?	☐Yes ☐No	☐Yes ☐No	
Alcohol?	☐Yes ☐No	☐Yes ☐No	How many drinks per week? _____
Caffeine?	☐Yes ☐No	☐Yes ☐No	How many cups per day? _____
Substance Abuse?	☐Yes ☐No	☐Yes ☐No	
Glasses / Contacts?	☐Yes ☐No		When was your last eye exam? _____
Dentures?	☐Yes ☐No		When was your last dental exam? _____
Seatbelts?	☐Yes ☐No		
Regular Exercise?	☐Yes ☐No		
E-Cigarette/Vape Status?	☐ Never ☐Current ☐Former		

MEDICAL HISTORY (Current and Past Medical Conditions):

High Blood Pressure ☐Yes ☐No
Diabetes ☐Yes ☐No
Heart Disease ☐Yes ☐No
Asthma ☐Yes ☐No
Stroke ☐Yes ☐No
Date _____
Cancer ☐Yes ☐No
Type _____
Anemia ☐Yes ☐No
Elevated Cholesterol ☐Yes ☐No
Seizures ☐Yes ☐No
Arthritis ☐Yes ☐No
Type _____
Thyroid Disease ☐Yes ☐No
Allergies (environmental) ☐Yes ☐No
Pneumonia/Bronchitis ☐Yes ☐No
Emphysema ☐Yes ☐No

Stomach Ulcers/Gerd ☐Yes ☐No
Hepatitis/Liver Disease ☐Yes ☐No
Gallstones/Gall Bladder Disease ☐Yes ☐No
Kidney Disease/Kidney Stones ☐Yes ☐No
Back Problems ☐Yes ☐No
Bladder or Kidney Infection ☐Yes ☐No
Prostate Disease ☐Yes ☐No
Gonorrhea/Syphilis/Chlamydia ☐Yes ☐No
Alcohol/Drug Abuse ☐Yes ☐No
Mental Illness ☐Yes ☐No
Blood Transfusion ☐Yes ☐No
HIV/AIDS ☐Yes ☐No
Tuberculosis ☐Yes ☐No
Anxiety/Depression ☐Yes ☐No
Other: ☐Yes ☐No
Specify _____
_____

Surgical History:

_____ *(Date)* _____
_____ *(Date)* _____

Most Recent:

PAP: _____ *(Year)* Lab Work _____ *(Year)* EKG _____ *(Year)*
Mammogram: _____ *(Year)* Colonoscopy _____ *(Year)*

Family History: *(Relationship: mother, father, brother, sister, paternal/maternal grandmother or grandfather, paternal/maternal aunt or uncle)*

Alcohol/Drug Abuse ☐Yes ☐No Relationship _____
Allergies ☐Yes ☐No Relationship _____
Arthritis ☐Yes ☐No Relationship _____
Asthma ☐Yes ☐No Relationship _____
Blood/Bleeding Disorder ☐Yes ☐No Relationship _____
Cancer ☐Yes ☐No Relationship _____
Type _____
Glaucoma ☐Yes ☐No Relationship _____
Heart Disease ☐Yes ☐No Relationship _____
Kidney Disease ☐Yes ☐No Relationship _____
Mental Illness/Suicide ☐Yes ☐No Relationship _____
Seizures/Convulsions ☐Yes ☐No Relationship _____
Stomach Ulcers ☐Yes ☐No Relationship _____
Stroke ☐Yes ☐No Relationship _____
Tuberculosis ☐Yes ☐No Relationship _____

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PATIENT INFORMATION

LAST NAME: _____

FIRST NAME: _____

Middle Initial: _____

Date of Birth: _____ / _____ / _____

SSN: _____ - _____ - _____

Phone: _____ - _____ - _____

Use the QR code above to access the on-line Application or access the Application at: www.butlerhealthclinic.org

How to use: Use your smart phone camera to scan over the QR code. You will then be prompted to follow a link. This link will lead you to the on-line Application.

CONSENT TO TREATMENT

I hereby request and consent to the rendering of health care by the Community Health Center (CHC). I understand that this clinic is staffed by a health care team which may include physicians, dentists, nurse practitioners, nurses, technicians, and other volunteers. I freely accept care from this healthcare team and acknowledge the establishment of the provider/patient relationship. I further understand that this healthcare team will provide information and/or care; however, I maintain the right to make all decisions regarding my care.

I understand that CHC may obtain medications for my treatment through Patient Assistance Programs (PA) sponsored by major pharmaceutical companies. If I meet the eligibility requirements for PAP, I authorize the CHC Medical Director or designee to sign my name on the medication order form. My name will only be signed on medication orders specifically for me as prescribed by my health care provider.

This consent is to remain in effect until it is revoked by me in writing.

Print Name _____Signature_____Date_____

AUTHORIZATION FOR VERBAL COMMUNICATION & MEDICATION PICK-UP

I authorize CHC to verbally communicate my medical information with the following individuals. The individuals listed below are also given permission to pick up my medications from the CHC if I am unable to pick them up in person.

_____ _____

Name (Please Print) Relationship to Patient

_____ _____

Name (Please Print) Relationship to Patient

ACKNOWLEDGEMENT AND RECEIPT

By signing below, I acknowledge the following:

- **I declare** that I have completed this application to the best of my ability and that all information provided is true and accurate.
- **I agree** to provide the following documentation: photo ID, proof of household income and a copy of my most recent tax return.
  (Proof of income is required to determine eligibility for services and medications.)
- **I agree** to update CHC with any changes to my income and/or status of medical insurance.
- **I have** received a copy of the following documentation:
  - -Patient Statement of Understanding
  - -HIPAA Notice of Privacy Practices
  - -Free Clinic Federal Tort Claims Act (FTCA)

Print Name _____Signature_____Date_____

PATIENT STATEMENT OF UNDERSTANDING

PLEASE REVIEW THE FOLLOWING CAREFULLY TO UNDERSTAND THE SERVICES PROVIDED BY THE COMMUNITY HEALTH CENTER (CHC) AND YOUR RESPONSIBILITIES AS A PATIENT.

- **I understand** that **ALL** services provided by the Community Health Center (CHC) are free of charge.
- **I understand** that services provided by CHC may include primary medical care, basic dental care, health & wellness programs, behavioral health, prescription assistance, case management, and patient education.
- **I understand** that CHC does not duplicate available services in the community.
- **I understand** that CHC does not provide emergency care. If I believe my concern is urgent or life-threatening, I will seek services at the nearest emergency room at my own expense.
- **I understand** that at times, I may be referred to another provider or specialist. Some providers or specialists may be able to provide services at a free or reduced cost, however, any expenses incurred through other providers and/or specialists are my responsibility. It is up to me to make financial arrangements/payments with the other provider and/or specialist directly.
- **I understand** that I am required to provide the following documentation by my **second visit**: photo ID, proof of household income, and a copy of my most recent tax return. Income documentation and tax return will be used to determine my eligibility for services at CHC and required on a yearly basis to continue services at CHC. I am required to update CHC with any changes to my income and/or status of medical insurance.
- **I understand** that failure to provide the documentation listed above on my second visit will result in services being **postponed** until I provide the requested documentation.
- **I understand** that I will apply for available health insurance or Medical Assistance, and I will provide proof of acceptance or denial to CHC.
- **I understand** that CHC will work to the best of its ability to provide medications at no cost to me. However, I am ultimately responsible for the cost of my medications.
- **I understand** that I will give CHC at least 24 hours' notice to cancel any appointment – **exception: Dental appointments require 48 hours' notice.** If I miss up to three (3) appointments at CHC without notifying the clinic in advance, CHC reserves the right to discharge me as a patient.
- **I understand** that I will keep all specialist referral appointments. If I do not directly call the specialist's office to cancel/reschedule a single appointment, **at least 24 hours in advance,** I will be denied future specialist referrals.
- **I understand** that CHC staff and volunteers are committed to treating patients with dignity and respect and that I am expected to respect the staff and volunteers who provide my healthcare.
- **I understand** that I am responsible for my care. It is my responsibility to follow the recommendations, treatments, and prescribed medication(s) offered by CHC.

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Patient Notice of Limited Liability for FTCA Deemed Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Independent Contractors

Notice to Patients To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner, board member, officer, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board members, officers, employees, or independent contractors who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic – Jean B Purvis Community Health Center (CHC).

JEAN B PURVIS COMMUNITY HEALTH CENTER OF BUTLER COUNTY

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HIPAA NOTICE OF PRIVACY PRACTICES

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.

If you have questions about this notice, please contact our office at 724.841.0980

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment, and health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" refers to individually identifiable health information, including demographic information, collected from you, or received by a health care provider, and that relates to your past, present, or future physical or mental health or condition. We reserve the right to change our privacy policy and terms of this notice provided the changes are permitted by applicable law, and to make new changes to notice provisions effective for all protected health information we maintain. When we make a significant change in our privacy practices, we will change this notice and post a copy clearly and prominently at our practice location. We will provide a copy of the new notice upon request. **You may request a copy of our notice at any time.**

The following describes ways we may use or disclose your health information.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use or disclose health information to provide, coordinate, or manage health care and any related services. This includes the coordination or management of health care with a third party, such as a referral to a specialist.

Healthcare Operations: We may use or disclose health information as necessary to make sure that all our patients receive quality care as well as operate and manage our office. This may include a sign-in sheet at the registration desk or calling you by name when the provider is ready to see you.

Disclosure to Others: Your health information may be used and shared by your physician, our office staff, and others outside of our office that is involved in your care and treatment to provide health care services to you, to support the operation of the clinic, and any other use permitted or required by law.

Appointment Reminders: We may use or disclose health information to contact you to remind you that you have an appointment with us or may have missed an appointment and/or to tell you about health-related benefits and services that may be of interest to you.

Health-Related Benefits and Services: We may use or disclose health information to tell you about health-related benefits and services that may be of interest to you.

Fundraising: We may use or disclose health information to contact you in fundraising efforts and, in the event, you prefer not to receive such communications, you can opt out of receiving them.

USES AND DISCLOSURES WITHOUT YOUR AUTHORIZATION

The following describes ways we may use or disclose your health information without your authorization such as for public health purposes, abuse or neglect reporting, research studies, funeral arrangements and organ donation, workers' compensation purposes, and emergencies. We may disclose health information when required by law, such as in response to a request from law enforcement in specific circumstances or response to valid judicial or administrative orders.

As Required by Law: We may disclose health information when required to do so by international, federal, state or local law.

Public Health Risks: We may use or disclose health information about you for public health activities, such as to prevent or control disease, injury, or disability, or to report child abuse, domestic violence, or disease or infection exposure.

To Avert a Serious Threat to Health or Safety: We may use or disclose health information to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

Health Oversight Activities: We may use or disclose health information to help health agencies during audits, investigations or inspections.

YOUR HEALTH INFORMATION RIGHTS

Your right to inspect and request a copy of your health information: You must submit a request in writing. Federal law, however, does create some exceptions to this right and exempts the following records: psychotherapy notes; and information gathered to be used in a civil, criminal, or administrative action or proceeding. In certain circumstances, we may deny your request and you may be entitled to request that our denial be reviewed.

Your right to amend incorrect or incomplete health information: If you feel that health information we have is incorrect or incomplete, you may submit a written request explaining the requested amendment.

Your right to request restrictions on disclosure of your health information: You may ask us not to use or share your health information for the purposes of treatment or health care operations.

Your right to an account of disclosures of your health information we have made: The accounting of disclosures does not apply to disclosure for treatment and health care operations or for disclosures we have made to you or at your request. You must submit your request in writing.

Your right to request confidential communications of your health information: such as sending mail to an address other than your home or by other means. Your written request must state how or where you would like to be contacted, and we will accommodate reasonable requests.

Your right to a paper copy of this notice: You may request a paper copy of this notice at any time. You may also obtain a copy of this notice on our website: www.butlerhealthclinic.org

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and this Notice. If we make a change to our practices, we will post the new Notice on our website: www.butlerhealthclinic.org

QUESTIONS AND COMPLAINTS

We are required by law to protect the privacy of your information, provide this Notice about our information practices, follow the information practices that are described in this Notice, and notify you following a breach of your health information. Questions or complaints regarding this Notice of Privacy Practices should be submitted in writing to Kimberly Reamer, Executive Director:

Jean B Purvis Community Health Center
103 Bonnie Drive
Butler, PA 16002
724.841.0980
www.butlerhealthclinic.org

Or you may submit a written complaint, no more than 180 days after the event, to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

You will not be penalized for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE: January 1, 2024