MEDICAL CLINIC

Opening the door for the good news of Jesus Christ through the practice of medicine and dentistry.

MEDICAL INTAKE FORM

Patient's Name: ____ Today's Date: ____________
Date of Birth : _____/_____/____ Age: _____ SSN#: ______-____-______
Male ☐ Female ☒ Race: ___________________ Email:_________________________________
Home Address: ____
City: ________________________ State: _______ Zip: ___________
Single ☒ Married ☒ Divorced ☒ Widowed ☒ Separated ☒
Home Phone: _________________ Cell Phone: __________________ Work Phone: ________________
Emergency Contact:
Name & Relationship __________________________________ Contact Number: _________________
Employer:________________________________ Employer's Address:_________________________
Name of Previous Physician: ________________________________ Phone: _____________________
Are you under the treatment of any medication at this time? Yes ☒ No ☒
If yes, please list and explain:

____

____

____

Please, list any allergies you might have:

____

____

Do you have any chronic health conditions? Yes ☒ No ☒ If yes, please explain:

____

____

____

I give my full consent to the Mission First Medical Clinic volunteer healthcare staff to provide me with care as they see best.

Your signature: _______________________________________ **Date:** _________________

Disclaimer: Mission First Medical Clinic has the capacity to meet a variety of medical needs. However, our clinic is limited in our examination equipment and laboratory capabilities. <u>Narcotic drugs are not stored at our clinic</u>. Unfortunately, our clinic may not have the capacity to assist in your long term care of certain chronic conditions or specialty services. Patients are seen by appointment only. The Mission First Medical Clinic should not be considered when facing an emergency care situation or trauma treatment center.

MEDICAL CLINIC

Do you have or have you had any of the following?

Please circle the following option to the best of your knowledge

Diptheria	Measles	Mumps	Chicken Pox	Scarlet Fever	Polio
Small Pox	Typhoid	Malaria	Pneumonia	Jaundice	Diarrhea
Rheumatic Fever	Asthma	Heart Disease	Smoking	Tuberculosis	High Blood Pressure
Gonnorrhea	Kidney Disease	Diabetes	Prostate Disease	Sickle Cell Disease	Heart Murmur
Hepatitis	Arthritis	Anemia	AIDS/HIV	Please List Other →	

Women Only: Are you pregnant? Yes ☐ No ☐ Unsure ☐ If so, what month? _______________
Number of miscarriages: ____________ Number of children: _______________
Last menstrual period: ______________ Last Pap Smear: _________________

List all surgeries you have had, reasons for them and dates:

____
____
____
____

Name any serious illness you have had and dates:

____
____
____
____

List any serious bodily injury you have had and dates of such:

____
____
____
____

Has anyone in your family had: (Check all that apply)
Cancer____ TB ____ Mental Illness ____ Diabetes ____ Heart Disease _____
Arthritis ____ Goiter ____ Obesity ____ Nephritis _____ Epilepsy _____ Hypertension ____

Are you a member of a church? Yes ☐ No ☐ If so, which one? _________________________
How did you hear about Mission First?

____

"Be anxious for nothing, but in everything by prayer and supplication with thanksgiving, let your requests be made known to God, and the peace of God which surpasses all comprehension, shall guard your heart and your minds in Christ Jesus." Philippians 4:6-7

MEDICAL CLINIC

For your partnership in your medical care at Mission First

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the staff at Mission First to use any part of my medical/dental record or medical/dental information in order to obtain any necessary medical or dental consultations so that they may diagnose and/or treat my medical or dental needs comprehensively. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with this signed document serving as my informed consent.

______________________________________ ___________________________

Signature Date

I understand that I am responsible for payment of services rendered **on the day of my treatment**. Should I not pay my required fee, then I may be denied further treatment at this facility until my accrued debt is paid in full. If I am a new patient and I fail to attend my initial appointment or fail to give 24 hour notice of my inability to attend my first appointment, I forfeit the right to be seen at Mission First. Also, I acknowledge that if I fail to appear for my scheduled appointment three times that I become ineligible for future treatment at this facility. Should I need to reschedule my appointment, I commit to calling 24 hours in advance of my appointment time to do so. Also, I agree that if I am 15 minutes late or more for my scheduled appointment, then I will need to be rescheduled for another time.

______________________________________ ___________________________

Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

MEDICAL CLINIC

Mission First Medical and Dental Clinic Financial Eligibility Determination Form

______________________ ___________________ ___/___/_____ __________

Last Name First Name Date of Birth Sex

Section 1:

Do you have dental insurance? Yes ☐ No ☐ Do you have Medicare? Yes ☐ No ☐

Do you have medical insurance? Yes ☐ No ☐ Do you have Medicaid? Yes ☐ No ☐

Each patient's eligibility to pay an administration fee for services rendered will be determined by the patient's price code. Each price will represent an office visit fee based on the patient's household income and the number of members in the household.

Please circle the cost code which applies to you:

Cost Code	Annual Income	Office Visit Fee
A	$25,001-UP	$25
B	$20,001-25,000	$20
C	$15,001-20,000	$15
D	$10,001-15,000	$10
E (minimum)	$0-$10,000	$5

**Exceptions: the only dental procedures which will have an exception to the above price codes will be prosthetic dentistry and crown and bridge procedures in which supply cost will be required. The only medical procedure which will have an exception will be minor general surgeries that need to be sent off for lab and any special x-rays.

Note: All patient fees will go to the upkeep of the clinic and not to the volunteer health staff.

Section 11:

I certify by my signature that to the best of my knowledge, the above is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification.

___________________________ __________________________________ __________

Signature of patient or guardian Signature of Mission First staff/volunteer Date

MEDICAL CLINIC

AUTHORIZATION TO RELEASE/FAX MEDICAL RECORDS PROTECTION OF HEALTH INFORMATION

I authorize the use or disclosure of the medical records/protected health information(PHI) as described below. By authorizing the use or disclosure of the records described below, I authorize the custodian of the records to forward via facsimile; my records/protected health information, for review or inspection by the person(s) identified below:

__________________________________ ___/____/________ _________-_____-_________

Patient's Name Date of Birth SSN

I authorize MISSION FIRST, INC. Medical/Dental Clinic to release and/or disclose my medical records/protected health information to:

Doctor: ____

The purpose of this request to release and/or disclose the medical records/PHI described above is for review by doctor listed above ______ or for _________________________.

__ I do not authorize the recipient to re-disclose the PHI described above without my prior written approval.

I understand that I have the right to revoke this authorization, in writing, at any time by notifying the requesting person. Such revocation will not affect actions taken by the requesting person prior to the date he/she received the written revocation.

I understand that my healthcare provider cannot condition medical treatment on whether I sign this authorization.

This authorization will expire upon my written revocation.

_____________________________ ___________________________ ____________

Print Name Signature Date

If signed by patients authorized representative, describe the representative's authority:

__ Patient is a ward; I am patient's guardian, appointed by the ______________ County Probate Court.
__ Patient is a ward; I am patient's guardian, appointed by the ______________ County Juvenile Court.
__ Patient is a ward; I am patient's parent or natural guardian.
__ Patient is a deceased; I am the patient's surviving spouse or I am the patient's surviving spouse or I am the executor or administrator of the patient's estate, appointed by the _____________ County Probate Court.
__ I am the patient's agent, empowered to make the foregoing request, as designated in the patient's general power of attorney.
__ I am the patient's agent, as designated in the patient's Durable Power of Attorney for Health Care.
__ Other ____

This Authorization to release protected information is designed to meet the requirements of a valid authorization as specified by the standards for privacy of individually identifiable health information and (the HIPPA privacy rule), 45CFR, part 160 and 164. The prescribed content of a valid authorization is found at 45 CFR 164. 508.

Revised 07/1/2020

MEDICAL CLINIC

MISSION FIRST LIABILITY AND MEDIA RELEASE FORM

I grant permission to Mission First, Inc. and its subordinates, to use my name and/or photographs for use in Mission First publications such as recruiting brochures, newsletter, and magazines, and to use my name and/or photographs on display boards, and to use my name and/or photographs in electronic versions of the same publications or on the Mission First, Inc. website or other electronic forms or media.

I hereby waive any right to inspect or approve the finished photographs or printed or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the photography.

I hereby agree to release, defend, and hold harmless Mission First, Inc. and subordinates, including any firm publishing and/or distributing the finished product in whole or in part, whether on paper or via electronic media, from and against any claims, damages or liability arising from or related to the use of the photographs without limitation.

I hereby agree that by participating in the activities of Mission First, Inc. that I will be fully responsible for any and all doctor, hospital and related medical expenses relating to any injuries or damages sustained while participating in the activity, travel or connecting therewith; waive and release Mission First, INc. from any claim of of any kind I may have relating to injuries or damages sustained while participating in the activity or travel in connection therewith; and indemnify and hold harmless Mission First, Inc. from any such claim that might be made.

Please check the paragraph below which is applicable to your present situation:
___ I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

___ I am the parent or legal guardian of the below name child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Date: _____________

Name (Please Print): ____

Address:____

(Street) (City) (State/Province) (Zip/Postal Code)

Date of Birth: _______________

Phone number(s): ____

Signature of participant: ____

Signature of parent or legal guardian (if under 18 years of age): ____

This form must be fully completed and returned to Mission First, Inc. prior to any participation with Mission First, Inc.

MEDICAL CLINIC

IMMUNITY FOR CHARITABLE AND VOLUNTARY MEDICAL SERVICES

According to MIssissippi Code Ann. Statue 73-25-38, any licensed physician or certified nurse practitioner who voluntarily provides needed medical or health services to any person without the exception of payment due to the inability person to pay for said services shall be immune from liability for any civil action arising out of the provision of such medical or health services provided in good faith on a charitable basis. Immunity under this section shall waiver in advance of the rendering of such medical services specifying that such services are provided without expectation of payment and that the licensed physician or certified nurse practitioner shall be immune as provided herein.

By signing this written waiver in advance of my medical service, I understand that the physicians, dentist, and practitioners are voluntarily providing medical service to me without any exemption of payment of payment or compensation for their services making them immune from liability for any civil action arising out of the provision of said services.

I understand that all fees collected by Mission First Medical and Dental Clinic will go to the upkeep of the clinic and supplies.

I understand that volunteer doctors, dentist, and practitioners will not receive any payment from patient's fee.

I also understand that by executing this written waiver, I agree to the above for the current visit and any following visits at the Mission First Medical and Dental Clinic.

Patient's Name (Print) ____

Patients Signature (PArent/Guardian if under 18 years of age) ___________________________________

Date _______________________

(A copy of this waiver will remain in the patient's medical record)

Revised 2/2022