Standard Application

Last Name: ____

First Name: ________________________ Middle Name: ______________________

Maiden Name: _______________________ Birth Date: _____________ (MM/DD/YYYY)

SSN/Tax ID: _________________________

Home Phone: ________________________ Work Phone: ______________________

Cell Phone: _________________________ Email: ___________________________

Street Address: ____

City: _________________________ State: _____________ Zip Code: ___________

County: _________________ Relationship to Head of Household: ______________________

Date of Application: _______________

How were you referred to this clinic? ____

Is this appointment for a car accident or work related injury? _______YES _______NO

If YES, date of injury.____________________________________

Gender: ______________ Marital Status: Single Divorced Widowed Married Separated

Race: You can choose up to two options.
- American Indian or Alaska Native
- Asian
- Black or African America
- Caucasian/White
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- Other

Housing Status: Homeless Renting Home Owner

How many years of school did you complete? (1-20) ________

What is the highest degree you have obtained? High School Diploma College Masters

Are you a full-time student at a 4-year college or university? _______

What is your preferred language for speaking? _______________ Reading? _______________

Residency Status: *(check one)*

_______ 72 hour boarder crossing card

_______ Alien with valid employee card

_______ Perm resident less than 5 years

_______ Perm resident greater than 5 years

_______ Student/ Tour/ Bus Traveler

_______ US Citizen

_______ Undocumented

Insurance: Do you have insurance?: Yes No

If so which insurance do you have?

_______ Blue Cross Blue Shield
_______ Medicaid
_______ NC Health Choice
_______ MedCost

_______ Cigna
_______ Medicare
_______ Humana
_______ United

Emergency Contact

______________________________ *(Full Name)*

______________________________ *(Relationship to Patient)*

______________________________ *(Street Address)*

______________________________ *(Home Phone)*

______________________________ *(City, State, Zip Code*

______________ / ______________ *(Work Phone)* *(Cell Phone)*

Additional Household Members

How many household members are in your home INCLUDING YOURSELF? _______(Include all adults and all minors.)

Please list the Name, Date of Birth and Relationship of all household members below:

______________________________ *Full Name* ______________ *Date of Birth* ______________ *Relationship to Patient*
Is this person employed? _____Yes _____No

______________________________ *Full Name* ______________ *Date of Birth* ______________ *Relationship to Patient*
Is this person employed? _____ Yes _____No

______________________________ *Full Name* ______________ *Date of Birth* ______________ *Relationship to Patient*
Is this person employed? _____Yes _____No

______________________________ *Full Name* ______________ *Date of Birth* ______________ *Relationship to Patient*
Is this person employed? _____ Yes _____No

______________________________ *Full Name* ______________ *Date of Birth* ______________ *Relationship to Patient*
Is this person employed? _____Yes _____No

______________________________ *Full Name* ______________ *Date of Birth* ______________ *Relationship to Patient*
Is this person employed? _____ Yes _____No

Patient's Income

1. Patient's Source of Income I: ______________________________
   (job, disability, SSI, child support, alimony, etc.)

   Income Amount: ____________________ per Week/Month/Year

2. Patient's Source of Income II: ______________________________
   (job, disability, SSI, child support, alimony, etc.)

   Income Amount: ____________________ per Week/Month/Year

3. Patient's Source of Income III: ______________________________
   (job, disability, SSI, child support, alimony, etc.)

   Total Income Amount: ____________________ per Week/Month/Year

Other Household Income (Complete only if other household members are working.)

Household Member (1)

Last Name: ______________________________

First Name: ____________________ Middle Name: ____________________

Birth Date: ____________ (MM/DD/YYYY) Gender: ____________________

Insurance Status: No Insurance Insured Uninsured

Is this person working or self-employed? __________ Employer Name ____________________

Income Verification (check one): ______ 2 – 4 check stubs ______ Letter from employer
______ Current IRS Tax Return

How often does this individual get paid? _____ Annually ______ Monthly ______ Every (2) weeks ______ Weekly

Household Member (2)

Last Name: ______________________________

First Name: ____________________ Middle Name: ____________________

Birth Date: ____________ (MM/DD/YYYY) Gender: ____________________

Insurance Status: No Insurance Insured Uninsured

Is this person working or self-employed? __________ Employer Name ____________________

Income Verification (check one): ______ 2 – 4 check stubs ______ Letter from employer
______ Current IRS Tax Return

How often does this individual get paid? _____ Annually ______ Monthly ______ Every (2) weeks ______ Weekly

Household Member (3)

Last Name: ____________________

First Name: ____________________ Middle Name: ____________________

Birth Date: ______________ (MM/DD/YYYY) Gender: ____________________

Insurance Status: No Insurance Insured Uninsured

Is this person working or self-employed? ____________ Employer Name ____________________

Income Verification (check one): ______ 2 – 4 check stubs ______ Letter from employer
______ Current IRS Tax Return

How often does this individual get paid? _____ Annually ______ Monthly ______ Every (2) weeks ______ Weekly

Household Member (4)

Last Name: ____________________

First Name: ____________________ Middle Name: ____________________

Birth Date: ______________ (MM/DD/YYYY) Gender: ____________________

Insurance Status: No Insurance Insured Uninsured

Is this person working or self-employed? ____________ Employer Name ____________________

Income Verification (check one): ______ 2 – 4 check stubs ______ Letter from employer
______ Current IRS Tax Return

How often does this individual get paid? _____ Annually ______ Monthly ______ Every (2) weeks ______ Weekly

Household Member (5)

Last Name: ____________________

First Name: ____________________ Middle Name: ____________________

Birth Date: ______________ (MM/DD/YYYY) Gender: ____________________

Insurance Status: No Insurance Insured Uninsured

Is this person working or self-employed? ____________ Employer Name ____________________

Income Verification (check one): ______ 2 – 4 check stubs ______ Letter from employer
______ Current IRS Tax Return

How often does this individual get paid? _____ Annually ______ Monthly ______ Every (2) weeks ______ Weekly

Patient Responsibility & Accountability Contract

Alliance Medical Ministry (AMM) is a faith-based organization that offers acute and chronic medical care to Wake County residents who are working (or live with a family member who works), but are uninsured. All services are provided according to a sliding fee scale which covers the physician consultation, lab work, and sample medications while securing a patient-doctor relationship that allows you ongoing, quality medical care and services.

Because of the increasing demand for new patient appointments, we must hold our patients accountable in order to meet the basic requirements necessary to maintain your doctor-patient relationship here at AMM. By signing your initials below, you are confirming that the information you've provided to AMM is correct. Also, your initials indicate that you agree to abide by the patient responsibilities listed in this contract in order to maintain your doctor-patient relationship. Failure to uphold any portion of this contract may result in immediate termination from care at AMM.

_____ I agree to be examined and evaluated by the medical staff of AMM and to be tested and treated as necessary.

_____ I agree to provide documentation and/or evidence of my household income every year to an AMM representative as a requirement for my continued care at AMM.

_____ I agree to pay my co-payment, based on a sliding fee scale, at the time of each appointment.

_____ **I understand that I need to call at least 24 hours in advance if I need to cancel or reschedule an appointment.** Multiple *no shows* will result in termination of care at AMM.

_____ **I understand that my appointment may be rescheduled if I arrive more than 15 minutes after my scheduled appointment time.**

_____ I agree to notify AMM of any change in address, phone number, or insurance status including Medicaid and Medicare.

_____ I agree to contact my drug store pharmacy or the pharmacy at AMM for a prescription refill when I have 5 days before my medication runs out.

_____ I agree to store any medications received from AMM away from children. I understand that my doctor may decide to start me on a medication with a sample. However, I am aware that samples will not be given on an ongoing basis and I may have to purchase the medicine from another pharmacy.

_____ I agree to bring the bottles for all medications I'm taking to each of my appointments.

I hereby authorize representatives of AMM to request and/or release any and all information concerning my employment earnings, financial affairs, medical history, applications for assistance, and any other information as required to determine eligibility for services at AMM and any other community services which may be considered in the course of my treatment.

You may revoke this authorization at any time in writing. Please note that this contract is valid for one year from the date signed/witnessed.

Patient's Name: ____
(PRINT)

Patient Signature: ____ Date:_______

AMM Representative: ____________________________________ Date: ______

Compassionate Medical Care for Our Working Neighbors

ALLIANCE MEDICAL MINISTRY

Date: ________________

RELEASE FORM

MEDICINE

I, ______________________________ give the following person(s) permission to pick up my prescriptions from Alliance Medical Ministries:

1. ____
2. ____
3. ____

RELEASE OF MEDICAL INFORMATION

I, ______________________________ give the following person(s) permission to obtain my medical information including test results, doctor's recommendations and treatment.

1. ____
2. ____
3. ____
4. ____

This release is valid one year from date of signature.

101 Donald Ross Drive • Raleigh, North Carolina 27610 • (919) 250-3320 • Fax (919) 250-3322
www.alliancemedicalministry.org

Security & Privacy of Information

Federal and state laws require health care providers to protect the privacy and security of patient information. The CCC will use and maintain appropriate safeguards to protect information in the database. Patients will receive the Participating Providers' HIPAA Notice of Privacy Practices, where applicable, which provides additional information about the providers' respective confidentiality policies. Information disclosed to Participating Providers based on this Authorization may be re-disclosed in accordance with applicable privacy laws.

Patient Authorization

- I understand that by signing this form, I give permission for all current and future CCC Participating Providers, and their employees and agents and business associates involved in my care, to see my personal health and financial records in the CCC database. Providers may see this information even if they are not my usual provider and they do not have my past medical records.
- I understand that my health information could include medical history or information regarding first time diagnosis or treatment of me for a communicable disease (such as sexually transmitted diseases, HIV/AIDS, tuberculosis or hepatitis), mental illness, alcohol and substance abuse.
- A Participating Provider may obtain information about past health care services I received at other CCC Participating Providers.
- I have reviewed the list of current CCC Participating Providers (Attachment A), and I understand that others may be added in the future.
- I acknowledge I have received a copy of this authorization.
- I understand that this authorization will be effective unless and until I appropriately cancel it or the CCC stops doing business.
- I understand that I have the right to cancel this authorization at any time by completing a Cancellation Form, which I can get from any Participating Provider. Cancellation does not affect information already shared and is effective only after the CCC receives a properly completed Cancellation Form and deactivates the information in the database.
- I understand that if I sign as a representative of a patient, I am certifying that I have authority under North Carolina law to make health care decisions for the patient.
- I understand that although my signature on this form permits CCC Participating Providers involved in my care to share my health and financial information, no Participating Provider may access my information in the database unless I go to that Participating Provider for treatment, and unless information about my past health care treatment has already been entered into the CCC database.
- **I understand that my decision about whether to participate in the CCC is completely VOLUNTARY and that no Participating Provider may condition my treatment on whether I sign this form. If I do not sign the form, CCC Participating Providers will not share my information with each other unless I give authorization for them to do so at a later time.**

My signature below indicates my authorization to have my health and financial information entered into the CCC database and shared with current and future CCC Participating Providers and their business associates.

Patient Name (PRINT) ____

________________________________ ________________________
Signature of Patient or Authorized Representative Relationship to Patient (if applicable)

Facility: ______________________________ DOB: ____________________

Witness ________________________________ Date ____________________

02/24/10

Attachment A

Current Participating Providers of the CapitalCare Collaborative are:

- Alliance Medical Ministry
- Duke Raleigh Hospital
- Rex Healthcare
- Urban Ministries of Wake County, Open Door Clinic
- Wake County Human Services
- Wake Co. Medical Society (including Project Access and Community Care of NC)
- Wake Health Services, Inc.
- WakeMed Health & Hospitals

ALLIANCE MEDICAL MINISTRY

HEALTH HISTORY

Name ______________________ Today's Date ____________

Age ________ Date of Birth ____/____/____ Occupation ______________________

Sex: ❐ Female ❐ Male Marital Status: ❐ Married ❐ Single ❐ Separated ❐ Divorced ❐ Widow/er

Do you have any health concerns? If so, please list.

____

____

____

PAST MEDICAL HISTORY: Check the box of conditions doctors have followed you for in the past:

- ❐ High Blood Pressure/Hypertension
- ❐ Diabetes ("sugar")
- ❐ Heart Attack/By-pass Surgery
- ❐ Mitral Valve Prolapse
- ❐ Stomach Problems
- ❐ Glaucoma
- ❐ High Cholesterol
- ❐ Thyroid Problems
- ❐ Heart Failure
- ❐ Stroke
- ❐ Intestinal Problems
- ❐ Psychiatric Illness
- ❐ Liver Disease
- ❐ Kidney Disease
- ❐ Heart Murmur
- ❐ Seizures/Epilepsy
- ❐ Reflux Disease
- ❐ Arthritis
- ❐ Abnormal pap Smear ❐ Cancer: Type & Location ______________________
- ❐ Other: ______________________

Have you ever had:	Yes	No
Positive tuberculosis test?	____	____
Rheumatic Fever?	____	____
Blood transfusion?	____	____

For Females:

When was your last menstrual period? ____________

Are your periods regular? ❐ Yes ❐ No

Number of times you have been pregnant? ____________

Complications? ____________

Number of children you have? ____________

Please list any operations or past hospitalizations (list any operations you have had including C-section):

____________ ____________ ____________

____________ ____________ ____________

Please list drug allergies:

____________ ____________

____________ ____________

____________ ____________

Please list all current medications (including vitamins, herbal & health food preparations):

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

ALLIANCE MEDICAL MINISTRY

PREVENTATIVE CARE: When was your last:

Tetanus Booster . . . . _______
Flu Shot . . . . _______
Pneumonia Vaccine . . . . _______
Hepatitis Vaccine . . . . _______
Flexible Sigmoidoscopy/Colonoscopy . . . . _______
Females: How often do you examine your breasts? . . . . _______
Males: How often do you examine your testicles? . . . . . . _______

Pap Smear . . . . _______
Mammogram . . . . _______
Cholesterol . . . . _______
Eye Exam . . . . _______
Bone Densitometry . . . . _______

SOCIAL HABITS

Have you ever smoked? ❒ No ❒ Yes. How many packs? _______ How many years? _________
Date quit if no longer smoking ______________________

Do you drink alcohol? ❒ No ❒ Yes. How many drinks per week? _______________
If yes: Have you ever felt the need to cut down on your drinking? ❒ Yes ❒ No
Have you ever felt guilty about your drinking? ❒ Yes ❒ No

Have you ever or are you currently using any of the following:
Marijuana ❒ Yes ❒ No
Cocaine ❒ Yes ❒ No
Heroin ❒ Yes ❒ No
Opioids ❒ Yes ❒ No

Any other recreational drug usage? ❒ Yes ❒ No If yes, please indicate the name of the drug(s)
____

Do you exercise outside of your job? ❒ No ❒ Yes. Number of days worked per week? _______________
How often do you wear your seat belts? ❒ always ❒ usually ❒ sometimes ❒ rarely/never

FAMILY HISTORY: Has anyone in your family had any of the following? (Check the appropriate box)

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers/ Sisters	Other
High Blood Presure/ Hypertension						
Heart Attack/ Heart Surgery						
Diabetes						
Stroke						
Cancer (Type/Location of Cancer)						
Osteoporosis						
Thyroid Problems						
Mental Illness						
Glaucoma						

Other: ____
____
____
____
____