PATIENT'S DEMOGRAPHICS AND AUTHORIZATION

Patient Demographics 病患個人信息 Date: _____ (mm/dd/yy)

Family Name 姓: _____ Middle Initial:_____ Sex 性別: M _____ F _____

First Name 名: _____ Chinese Name 中文姓名: _____

Date of Birth 出生月/日/年: _____ SSN 身分證號碼: :_____

Marital Status 婚姻狀況: ( ) Single ( ) Married ( ) Widowed ( ) Other_____

Address 地址:_____

City 城市: _____ State 州: _____ Zip 邮编: _____

電話 Home Phone: ( ) _____ Can we leave message 留言? ( ) Yes ( ) No

Work/Mobile: ( ) _____ Can we leave message 留言? ( ) Yes ( ) No

Email: _____ ( ) Opt out of CCACC Health E-newsletter

Pharmacy 藥房名: _____

Pharmacy Address 藥房地址: _____

Pharmacy Tel. 藥房電話: _____ Pharmacy Fax 藥房傳真: _____

Authorize to share health information with your representative? 授權給代表人分享醫療信息

If yes, name of individual _____ Relationship with patient _____

Email: _____ Tel: _____

Emergency contact name & phone number (different from home) 緊急聯絡人

Name 姓名 _____ Phone 電話 _____ Relationship 關係 _____

Signature of Patient /Authorized Representative (簽名/授權代表簽名)

_____

Print Name (正楷)

MEDICAL HISTORY
病歷

病人姓名 Name: _____ Date Of Birth: _____

Past Medical History and Review of Systems

Please circle the problems you had before or have now:
請圈選曾患過或現有之症狀

1. High blood pressure 高血壓
2. Diabetes 糖尿病
3. Cancer 癌症
4. Heart disease 心臟病
5. Chest discomfort 胸部不適
6. Shortness of breath 氣短
7. Swollen ankles 腳腫
8. Dizziness 頭暈
9. Palpitation 心悸
10. Frequent urination 頻尿
11. Rheumatic fever 風溼熱
12. Asthma 哮
13. Bronchitis 支氣管
14. Pneumonia 肺
15. Persistent cough 久
16. T.B. 結核病
17. Hay fever 枯草
18. Abdominal pain 腹痛
19. Indigestion 消化不良
20. Nausea 噁心
21. Vomiting 嘔吐
22. Constipation 便祕
23. Diarrhea 腹瀉
24. Blood in stool 便血
25. Peptic ulcer 消化性潰瘍
26. Weight loss 體重減輕
27. Hemorrhoids 痔瘡
28. Gallbladder disease 膽囊病
29. Colitis 大腸炎
30. Hepatic disease 肝病
31. Change in bowel habit 大便習慣改變
32. Thyroid disease 甲狀腺疾病
33. Irradiation 放射治療
34. Headache 頭痛
35. Kidney disease 腎臟病
36. Kidney stone 腎結石
37. Urinating problem 泌尿問題
38. Arthritis 關節炎
39. Low back pain 腰背痛
40. Skin disease 皮膚病
41. Blood disorder 血液病
42. Venereal disease 性病
43. Anxiety 焦慮症
44. Depression 憂鬱
45. Anemia 貧血
46. Gout 痛風

Other 其他:_____

_____

Allergies to Medications, X-Ray dyes, or Other Substances?
對藥物X光顯影劑或其他醫藥物有無過敏？ Yes是 No無

Name of Medicine 藥物名稱	Type of Reaction 反應狀況
_____	_____
_____	_____

Regular medication (name and dosage) 日常服用之藥名及劑量:

_____

_____

Operations 曾作過之 手術:

_____

Do you smoke 您抽菸嗎？ No 不

Yes 有 how many packs/day 每天包數 _____

Do you drink 您喝酒嗎？ No 不

Yes 有 how much/often 數量/次數 _____

Immunization history and preventive medicine 疫苗接種及預防醫學記錄:

Pneumonia vaccine 肺炎疫苗	No 無	Yes 有•, When 何時？ _____
Flu shot 流行性感冒	No 無	Yes 有•, When 何時？ _____
Hepatitis B 乙型肝炎	No 無	Yes 有•, When 何時？ _____
Tetanus 破傷風	No 無	Yes 有•, When 何時？ _____

The most recent date of the following exams 曾於何時作過下列 檢查？

Pap smear 子宮頸抹片	_____	Breast exam 乳房檢查	_____
Mammogram 乳房攝影	_____	Stool for blood 大便潛血	_____
Prostate exam 攝護腺	_____	Cholesterol check 膽固醇	_____

Family History 家族史

Has any member of your family (parents, grandparents, siblings) ever had the following?
您的祖父母, 父母, 兄弟姊妹曾患有下列疾病嗎？

Illness 病名	Family Member 家屬關係	Age of Onset 發病年齡
Cancer (type) 癌症(種類) _____	_____	_____
High blood pressure 高血壓	_____	_____
Diabetes 糖尿病	_____	_____
Stroke 中風	_____	_____
Mental disease 精神疾病	_____	_____
Bleeding disease 出血疾病	_____	_____
Others 其他: _____	_____	_____

Signature 簽名:_____ Date 日期:_____

PATIENT CERTIFICATION AND CONSENT FORM
病人保證及同意書

I certify that all of the information provided to CCACC Health Center is true and accurate to the best of my knowledge. I hereby voluntarily consent to medical treatment by the medical staff and providers of CCACC Health Center. I further consent to the use and disclosure of my protected health information for treatment, payment, operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) without a written authorization. A copy of this agreement may be used in place of the original. This authorization is valid until I rescind it in writing.

我保證所有提供給美京•泛亞醫療中心的資料，就我所知都是正確的。我謹此同意接受美京•泛亞醫療中心醫師及醫療人員的診治。我也同意美京•泛亞醫療中心可以在聯邦醫療保險轉移及責任法案 (Health Insurance Portability and Accountability Act) 規定的範圍內，為了治療、付款、手術及其他目的，轉移我的個人醫療資料，不需要再簽署一份同意書。這份同意書的影印本與原件同樣有效。這項授權在我以書面申請作廢之前，一直有效。

_____ _____

Signature of Patient or Parent/ Legal Guardian
病人或法定監護人簽名

Date
日期

_____

Print Name 正楷

FINANCIAL POLICY

1. As a courtesy to our patients, we submit claims to most insurance companies. Although we participate with several managed care plans, the balance that your insurance company does not cover is ultimately your responsibility. In order to ensure your claim is processed promptly, it is necessary that we have all pertinent information at the time services are rendered. This information includes a current copy of your insurance card(s) and a valid referral (HMO/POS/MCares Program).
2. All applicable copays are due at the time of service.
3. New patients without valid health coverage are expected to pay out-of-pocket at the time of service. This does not apply to patients who have MD Medical Assistance, Medicare, or any HMO, POS, PPO, or MCares Program with currently participating providers.
4. If your policy (HMO/POS) requires a referral for specialty services, we will make every effort to alert you when a new referral is necessary. IT IS ULTIMATELY YOUR RESPONSIBILITY TO PRESENT A VALID REFERRAL FOR EVERY VISIT, BEFORE YOU ARE SEEN. Please note the number of visits allowed by your PCP and the length of time for which your referral will be valid. We will not treat any patient without a valid referral at the time of service.

Remark:
As we extend our efforts to set your appointment at a time most convenient for you, we do require a 24-hour cancellation notice. There is a $25.00 charge per missed appointment if notice is not provided within this timeframe.

We reserve the right to dismiss any patient from our practice who exceeds a reasonable number of missed appointments in any calendar year.

I HAVE READ AND AGREE TO THE ABOVE POLICIES:

_____ _____

Name (Print/Typed) Date

_____ _____

Signature Witness Signature

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM
Patient Notice of Limited Liability of
FTCA-Deemed Volunteer Free Clinic Health Care Professionals
Notice to Patients

To be provided to the individual patient before health care services are rendered, except in emergency cases, when notice may be provided as soon as following 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 whom 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 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)).

Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by this federal law.

Acknowledged

_____

(Patient Signature)

_____

(Patient Name, printed legibly)

_____

(Date)

CCACC Health Center

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
CCACC Health Center's Notice of Privacy Practices.

The confidentiality of your protected health information is important to us. This is a summary of the CCACC Health Center Notice of Privacy Practices, which contains a more detailed description of how our clinic will protect your health information, your rights as a patient, and our practices in dealing with patient health information.

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you, and in order to obtain payment for our services. We may also disclose your health information for certain limited operational activities, such as quality assessment, licensing, accreditation, and training.

Uses and Disclosures Not Requiring Your Authorization In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care, unless you object;
- For certain limited research purposes;
- For purposes of public health and safety, or to avert a threat to health and safety;
- To government agencies for purposes of their audits, investigations, and other oversight activities;
- To government authorities to report or prevent abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas, or as otherwise required by law;
- For organ or tissue donations, or to the coroner or medical examiner;
- For workers' compensation;
- To business associates who may help us with clinic services.

Uses and Disclosures Based on Your Authorization Except for the circumstances stated above and as allowed under the federal Health Insurance Portability and Accountability Act (HIPAA), we will not use or disclose your health information without your written authorization.

Patient Rights As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions on how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices;
- To complain to the clinic or government agencies;
- To revoke any authorization in writing;
- To obtain more information about our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please contact the Privacy Officer (Clinic Director) at 240-393-5950.

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Practice's Privacy Notice.

_____ _____

Name of Individual (Printed) Date of Birth

_____ _____

Signature of Individual or Personal Representative Relationship if other than patient

PATIENT GRIEVANCE POLICY

POLICY NO: 506

POLICY:

This policy ensures that all patients who visit the Clinic are treated with respect, consideration, and dignity.

PROCEDURE:

All patients are assured confidential treatment and non-disclosure of records, and are afforded the opportunity to approve or refuse the release of such information, except as otherwise permitted by law, third-party payment contracts, or when release is required by law. Each patient will be informed of the name and role of any person providing health care services. The Clinic's Patient Bill of Rights will be posted in the waiting area in a location visible to all patients. If at any time during the visit the patient is dissatisfied with the treatment provided, including unprofessional behavior by staff, the patient has the right—and is encouraged—to file a grievance. Grievances must be submitted to the Medical Director or Clinic Director. All complaints should be submitted in writing, and a written response will be provided within two weeks. The Medical Director and/or Clinic Director will take the following actions:

- Conduct a thorough investigation of all complaints and maintain an office file.
- Maintain the anonymity of patients, staff, and volunteers when required.
- Seek medical, legal, or other professional advice as warranted.
- Administer recommended disciplinary action.

Staff and volunteers may also submit letters of complaint regarding patients and forward written comments and witness statements to the Medical Director and/or Clinic Director.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION
For eClinicalWorks

I, _____ [PATIENT NAME], a patient at CCACC Health Center ("My Clinic"), understand that eClinicalWorks is a computer-based health information exchange comprised of member healthcare providers like My Clinic (members of eClinicalWorks are called "eCW Members") whose purpose is to provide improved health care to individuals like me by allowing providers who treat me to have access to my medical records. I understand that, unless I notify My Clinic that my medical information may no longer be shared with eClinicalWorks, my medical information (as defined below) will be provided to eClinicalWorks and will be available to eCW Members for purposes of providing me with health care services as further described below, and as otherwise may be permitted by law. However, I understand that even if I notify My Clinic and request that my medical information no longer be shared, my medical information will continue to be available to eCW Members through eClinicalWorks in certain limited situations as permitted by law (for example, in order to avert a serious threat to the health and safety of myself or others).

- *Purpose of use or disclosure of my medical information.* I am authorizing the sharing of my medical information with eClinicalWorks, which allows eCW Members to more easily share my medical information, as defined below, for the purpose of providing me with health care services.
- *Information that is covered by this Authorization.* This Authorization covers information about me that is created or received by My Clinic, as well as other eCW Members, in the course of providing health care services to me, including but not limited to medical, personal, and family household information (together called "my medical information"). This Authorization also covers medical information that eCW Members receive from other providers.
- *Who may receive, use, or disclose my medical information.* I am authorizing only eClinicalWorks to receive, use, and disclose my medical information among eCW Members, including their staff. This Authorization does not allow the disclosure of my medical information to individuals or entities other than eClinicalWorks and eCW Members, except as otherwise permitted or required under federal or state law.
- *Term of Authorization.* This Authorization will remain in effect, unless revoked by me, for a period of ten (10) years from the date I sign this Authorization or any shorter period that may be required by law.

I understand that I may at any time make a written request to My Clinic, or any other eCW Member, to inspect or obtain a copy of my medical information and that the eCW Member will either contact me for a convenient time to inspect or copy my medical information or provide me with a copy or summary of my medical information. I further understand that I may obtain from My Clinic or any other eCW Member a complete list of eCW Members. I understand that a copy of this Authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.

I understand that the medical information disclosed under this Authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected by law to the same extent as such medical information was protected by law while solely in the possession of the eCW Member.

I understand that I may refuse to sign this Authorization at any time for any reason and that my refusal to sign this Authorization will not affect the commencement, continuation, or quality of treatment I receive by My Clinic or any other eCW Members, unless otherwise permitted by law.

I understand that eCW Members will not sell or receive compensation for the use or disclosure of medical information that is identifiable to me.

I understand that I may revoke this Authorization at any time and that such revocation will not affect the commencement, continuation, or quality of treatment I receive by eCW Members. In order to revoke this Authorization, I understand that I should submit to My Clinic or any other eCW Member a written request to revoke this Authorization. The revocation will be effective upon receipt by an eCW Member of my written request to revoke, except to the extent that action already has been taken in reliance on this Authorization.

I have read and understood the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my medical information. Accordingly, I knowingly and voluntarily authorize any eCW Member to use or disclose my medical information in the manner described above. I understand and agree that this Authorization applies only to the extent that an Authorization is required by law in order for eCW Members to use or disclose my medical information in the manner described above.

I understand that I can notify My Clinic or any other eCW Member at any time of my wish to revoke this Authorization and no longer share my health information electronically.

_____ _____

Signature of Patient Date

If the patient is a minor or otherwise unable to sign this Authorization, please complete the following and provide a copy of documentation that authorizes you to act as the personal representative:

_____ _____ _____

Signature of Personal Representative Relationship Date

_____ _____

Printed Name of Personal Representative Staff Signature/ Title

Strategy for urgent and emergency situations

CCACC URGENT SITUATIONS STRATEGY

Since CCACC Health Center mainly takes care of chronic medical conditions, whenever patients have urgent or emergency situations, please be advised of the following strategies:

1. In the case the patient needs to be seen before the next scheduled appointment, our manager will arrange the patient to be seen at the earliest available appointment.
2. If the patient's condition is relatively urgent, he/she should see the local practitioner or urgent care at his/her own cost. A list of doctors can be found from the local yellow page, newspapers, or online.
3. If the patient's condition is a life threatening emergency, he/she should call 911 or go to the local emergency room at his/her own cost.

病情有特殊與緊急狀況之處理

由於 CCACC 健康醫療中心主要治療非急性之疾病，若其間病人有特殊或緊急之狀況，請按以下建議處理:

1. 若病情需要在下一次預約之前覆診，門診經理會安排病患提前回診。
2. 若病情相對緊急，可到其他私人診所或 urgent care clinic 看病（可從黃頁或報紙查閱），費用自行處理。
3. 若病情危急或有生命危險，請打911或到附近之急診室就醫，費用自行處理。

_____

Signature of Patient or Relative 病患或家屬簽名

MONTGOMERY COUNTY SAFETY-NET PROGRAMS APPLICATION

COUNTY OFFICIAL USE ONLY:

eICM Contact ID: _____

Case Number: _____

Head of Household Name (Last, First, Middle)	Home Telephone	Work Telephone	Cell Telephone

Where Do You Live? (Number and Street)	Apt. #	City	State	Zip Code

Mailing Address (If different from home address)

What language do you speak? ☐ **English** ☐ **Spanish** ☐ **Amharic** ☐ **French** ☐ **Korean** ☐ **Mandarin** ☐ **Vietnamese** ☐ **Other** _____

Are you or anyone in your household pregnant? ☐ **Yes** ☐ **No** **If yes, who?** _____ **Due Date** _____

Have you ever received a county health program benefit program? ☐**Yes** ☐**No** Under what name? _____

SECTION A. HOUSEHOLD MEMBERS

Fill in the blanks for all the people in your household. Check **YES** for each person you are applying for. Check **NO** for each person you are not applying for. Check services you are requesting.

Please complete for each person who has a Social Security number

APPLYING FOR	NAME (Last, First, Middle)	RELATION TO YOU:	DATE OF BIRTH (MM/DD/YY)	GENDER	MARITAL STATUS	*RACE (Indicate below for each person)	*ETHNICITY	SOCIAL SECURITY NUMBER (SSN)
☐ MONTGOMERY CARES ☐ CARE FOR KIDS ☐ SENIOR DENTAL				**M** =Male **F**= Female **NB=**Nonbinary **GQ** = Genderqueer/ Genderfluid **MTF** = Transwoman/ woman of transgender experience **FTM** = Transman/ man of transgender experience	**M** = Married **S** = Single **D** = Divorced **P** = Separated **W** = Widowed	A = Asian B = Black/African American C = White N = American Indian or Alaska Native P = Native Hawaiian or Pacific Islander (You may select more than one code) MENA = Middle Eastern or North African	H/L = Hispanic/ Latino N/L = Non-Hispanic/ Non-Latino	
☐ Yes ☐ No		SELF					☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	

***You do not have to give information about your race/ethnicity. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter codes for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.**

SECTION B. ADDITIONAL INFORMATION

Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based

SECTION C. EARNED INCOME

Does anyone in your household receive any income from employment? ☐ Yes ☐ No If yes, list all gross income (from full or part-time employment, self-employment, babysitting, odd jobs, day work, roomer/boarder payments)

NAME (Last, First, Middle)	EMPLOYER	RATE OF PAY (HOURLY)	NUMBER OF HOURS WORKED	GROSS AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED WE = Weekly BW = Bi-weekly MO = Monthly	JOB START DATE (MM/DD/YY)	JOB END DATE (MM/DD/YY)	STUDENT STATUS (Full or Part-time)

SECTION D. UNEARNED AND OTHER INCOME

List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others, and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

PERSON RECEIVING INCOME	TYPE (For benefits, Include Claimant ID#)	GROSS AMOUNT RECEIVED	HOW MANY TIMES A YEAR?

SIGNATURE SECTION

I certify that the information I have provided above is true to the best of my knowledge and I give permission for Montgomery County to make any necessary contacts to check my statements. I have read and agree to the rights and responsibilities in this application packet. I know that I can be penalized if I knowingly give false information, and I declare under penalty of perjury that I do not have health insurance coverage and the facts I state in this application are true, correct, and complete to the best of my ability, belief, and knowledge.

Signature of Applicant/Recipient	Print (Name)	Date