NEW HEIGHTS CLINIC
Sharing a message of hope through healthcare.

NOTICE TO PATIENT

The mission of New Heights Clinic is to provide quality healthcare to those without health insurance and who cannot afford to pay for their care.

New Heights Clinic is a free medical clinic open part-time only and staffed almost entirely by volunteers. This creates some limitations to our services. We desire our patients to be fully aware of our limitations and to understand the responsibility they have for their care. Please read this document carefully and sign.

- I understand that New Heights Clinic is only open part-time and cannot respond to urgent, immediate medical problems.
- I understand my need to notify the clinic by noon the day before my appointment to confirm my attendance. I am aware that appointments that are not confirmed will be cancelled and a waiting patient will receive my appointment slot.
- I understand that all services provided at **New Heights Clinic are absolutely free**. I am aware that I will be responsible for charges associated with tests, procedures or consultation that are required at outside facilities or clinics. I can explore payment options with those facilities.
- I am aware it is my responsibility to obtain the medications prescribed by the Health Care Provider. New Heights Clinic will make every effort to assist patients in obtaining medications. At times samples are available for distribution to patients, but I am aware there is no guarantee of consistent sample availability. New Heights Clinic does not prescribe controlled substances (narcotics).
- I understand it is my responsibility to notify New Heights Clinic at least 2 weeks before a medication refill is needed.
- I understand that New Heights Clinic is unable to guarantee I will see the same physician at each patient visit. However, every effort will be made to schedule patients with providers that are familiar with their care.
- I understand that each time I visit New Heights Clinic a record is made of the visit. Typically, this record will contain symptoms, examination, test results, diagnosis, treatment and plan for future care or treatment. Although this record is the physical property of New Heights Clinic, the information belongs to me. I have a right to the following:
    - Request a restriction on certain uses and disclosure of information.
    - Inspect and obtain a copy of my record.
    - Request communication of my health information to alternate locations.
    - Revoke my authorization to use or disclose health information.

Patient Notice of Limited Liability of Free Clinic Federal Tort Claims Act

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 form the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Dept 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)). **This 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.**

☐ **I understand the above and agree to comply with the policies of New Heights Clinic.**

☐ **I consent to receiving services at New Heights Clinic, which may include assessment, routine diagnostic procedures, medications and such medical treatment as the attending physician/Nurse Practitioner/Physician's Assistant considers to be necessary for my care. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examination or treatment at this clinic.**

_____ _____

Signature **Date**

Original to chart
Copy to patient

NEW HEIGHTS CLINIC PATIENT INFORMATION

___ New
___ Seen within last year
___ Seen more than one year ago

Date _____

Name _____ Date of Birth _____ Age _____ Sex _____
Last First Mid

Address _____
Street City State Zip

Telephone _____
Home Work Message

Social Security _____ Number in household _____ Monthly income _____

Emergency Contact _____

Parent/Guardian Information _____
Name Relationship

Address _____
Street City State Zip

Telephone _____
Home Work Message

Previous or current medical provider _____

PLEASE CHECK THE RESPONSES THAT APPLY TO THE ABOVE PATIENT:

County of Residence		Marital Status		Ethnic Heritage		Health Insurance
Clark	☐	Single (14 & above)	☐	White (non Hispanic)	☐	Y N
Cowlitz	☐	Child (under 14)	☐	Black/African American	☐	What kind?
Skamania	☐	Married	☐	Asian/Pacific Islander	☐	_____
Multnomah	☐	Separated	☐	Native American (Indian)	☐	
Other	☐	Divorced	☐	Hispanic/Spanish	☐	
		Widowed	☐	Other	☐	
		Other	☐			

Patient/Guardian Employment Status		Household Income Sources (Patient or Family Member)		How did you hear about our clinic?	
Full-time (comp over 25 employees)	☐	Wages	☐	Friend/Relative	☐
Full-time (comp under 25 employees)	☐	Welfare/Public Assist	☐	Health Dept	☐
Part-time	☐	Unemployment	☐	Newspaper/Flyer	☐
Unemployed	☐	Social Security	☐	Hospital	☐
Self-employed	☐	SSI-Federal	☐	School	☐
Temporary Service	☐	None	☐	Other	☐
		Other	☐		

Office Use Only					
Upper Respiratory	☐	Ear Infection	☐	UTI	☐
Sore Throat	☐	Flu Symptoms	☐	Eye	☐
Rhinorrhea	☐	Sinus Pain/Infection	☐	Other	☐
Dermatologic Problem	☐	Orthopedic Problem	☐		

I hereby consent to such medical treatment that may be advisable by any of the licensed medical providers of the New Heights Clinic.

X _____
Signature of patient (or parent if patient is under 14 years of age) Date

New Heights Clinic Adult Health Questionnaire

Name: _____ Marital Status: _ Single _ Married _ Separated _ Divorced
Date of Birth: _____ Age: _____ Education: __ Grade _ H.S. _ Voc _ College
Todays Date: _____

PRESENT

List the medical problems that other doctors have diagnosed: _____

_____ _____ _____

ALLERGIES: Medication, Food, Latex?
(list the product and reaction you had)

_____
_____
_____

MEDICATIONS
Include the frequency and dose if you know them. Include non-prescription drugs, vitamins, birth control pills.

_____
_____

SOCIAL HISTORY

Tobacco: ☐Cigarettes pks per day ___ Number of years ____ Year quit ____
☐None ☐Cigar

Alcohol Average drink per ☐day ☐week ☐year ☐none

Do you have a problem with drinking or other drugs? ☐Yes ☐No ☐Maybe

Which recreational drugs do you use? _____

Caffeine ☐None ☐Coffee ☐Tea ☐Cola ☐Cups per day

Exercise ☐Sedentary (little exercise) ☐Mild Exercise (climb stairs, walk) ☐Occ Vigorous exercise (work or recreation-less than 4 x/wk) ☐Reg Vigorous exercise (work or recreation greater than 4x/wk)

Religious Background _____

Is faith or religion or spirituality an important part of your life? ☐Yes ☐No How? _____

_____
_____

PAST HEALTH

SURGERIES

Year	Operation	Hospital

OTHER HOSPITALIZATIONS:

Year	Problem	Hospital

FAMILY HISTORY:

Relationship	Age	Age at Death	Significant health problems or cause of death
~Father			
~Mother			
~Siblings			
~Children			
~Grandparents			

Have any relatives had: Relationship

AIDS	
Diabetes	
Cancer	
High Blood Pressure	
Asthma/Hay Fever	
Stroke	
Mental Illness	
TB	
Obesity	
Arthritis	
Obesity	

OCCUPATION HISTORY:

☐ Working ☐ Unemployed
☐ Retired ☐ Disabled

Starting with your most recent job, list the type of work you have done:

	Type of work	Number of years
1		
2		
3		

EXPOSURE

☐ Fumes & Dust ☐ Radiation
☐ Lead or Mercury ☐ Loud Noises
☐ Coal Asbestos ☐ Heavy Lifting
☐ Other:

OTHER PROBLEMS

Check if you have or have had any of these symptoms to an unusual or significant degree:

☐ Headache
☐ Fainting
☐ Dizziness
☐ Ear Trouble
☐ Sinus Trouble
☐ Stuffy Nose
☐ Allergy
☐ Hoarseness
☐ Trouble Seeing
☐ Trouble Hearing
☐ Cough
☐ Wheezing
☐ Pleurisy
☐ Shortness of breath
☐ when you lie down
☐ Night Sweats
☐ Chest Pain
☐ Cough Up Blood
☐ Trouble Swallowing
☐ Indigestion
☐ Heart Burn
☐ Stomach Pain
☐ Vomiting Blood
☐ Blood in Stool

☐ Change in stool
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Chest Pain
☐ Irregular Heart Beat
☐ Ankle Swelling
☐ Increased Urination
☐ at night
☐ Leg Pain w/ walking
☐ Joint Pain
☐ Back Pain
☐ Numbness
☐ Varicose Veins
☐ Hot Flashes
☐ Nervous
☐ Depressed
☐ Difficulty Sleeping
☐ Decreased Appetite
☐ Weight Change
☐ Difficulty Concentrating
☐ Pain with Urination
☐ Blood in Urine
☐ Frequent Urination
☐ Change in bowel habits

☐ Prob with Intercourse
☐ Seizures
☐ Asthma
☐ Ulcers
☐ Gall Bladder Trouble
☐ Colitis
☐ Liver Disease
☐ Anemia
☐ Blood Disorder
☐ Heart Trouble
☐ Heart Murmur
☐ Rheumatic Fever
☐ Enlarged Heart
☐ High Blood Pressure
☐ Phlebitis
☐ Diabetes
☐ Thyroid Disease
☐ Kidney Disease
☐ Urinary Tract
☐ Infections
☐ Infertility
☐ Impotence
☐ Frigidity
☐ Dark Stool (black)

AIDS:

☐ Are you concerned you might have AIDS?

☐ Did you have a blood transfusion between 1978-1983?

☐ Have you given yourself stree drugs with a needle?

☐ Are you homosexual or bisexual?

☐ Have you had intimate contact with someone known to have AIDS?

What other doctors do you use? _____

When was your last complete exam? _____

Have you had any recent:

Blood Work?	Yes	When?	Where?	No	☐
EKG?	Yes	When?	Where?	No	☐
Chest X-Ray?	Yes	When?	Where?	No	☐

WOMEN ONLY

MENSTRUAL HISTORY:

Date of last period? _____
Frequency of periods? _____
Date of last PAP? _____
Number of Pregnancies: _____
Number of Deliveries: _____

Do you have any menstrual problems? Yes ☐ No ☐

☐ Heavy Periods
☐ Irregular Periods
☐ Painful Periods
☐ Spotting

Other menstrual problems: _____

Signature of Patient: _____ Date: _____

Form Reviewed by: _____ Date: _____

NEW HEIGHTS CLINIC

SHARING A MESSAGE OF HOPE THROUGH HEALTH CARE

MESSAGE OF CONFIDENTIALITY

There are occasions when we need to communicate a report or message to you and are unable to get in touch with you at your home. To contact you in a timely manner and at the same time maintain strict confidentiality, we ask for the following information:

If we are unable to reach you at your home phone number, may we contact you at work?
YES _____ NO_____ #_____
May we contact you on your cell phone?
YES _____ NO_____ #_____
May we leave a message on your voice mail or answering machine?
YES _____ NO_____
Other than yourself is there a family member or friend with whom you would allow us to discuss your medical information:
YES _____ NO_____

_____

CONTACT NAME RELATIONSHIP TELEPHONE #

_____

CONTACT NAME RELATIONSHIP TELEPHONE #

_____

PRINT NAME

_____

PATIENT'S SIGNATURE DATE