



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 from 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 Date _____
 Seen within last year
 Seen more than one year ago

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

Patient's Primary Spoken Language _____ Interpreter Needed: YES NO

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 <input type="checkbox"/>	Single (14 & above) <input type="checkbox"/>	White (non Hispanic) <input type="checkbox"/>	Y N
Cowlitz <input type="checkbox"/>	Child (under 14) <input type="checkbox"/>	Black/African American <input type="checkbox"/>	What kind?
Skamania <input type="checkbox"/>	Married <input type="checkbox"/>	Asian/Pacific Islander <input type="checkbox"/>	
Multnomah <input type="checkbox"/>	Separated <input type="checkbox"/>	Native American (Indian) <input type="checkbox"/>	
Other <input type="checkbox"/>	Divorced <input type="checkbox"/>	Hispanic/Spanish <input type="checkbox"/>	
	Widowed <input type="checkbox"/>	Other <input type="checkbox"/>	
	Other <input type="checkbox"/>		

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

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
 Today's 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 Mild Exercise Occ Vigorous exercise Reg Vigorous exercise
 (little exercise) (climb stairs, walk) (work or recreation-less than 4 x/wk) (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			OTHER HOSPITALIZATIONS:		
Year	Operation	Hospital	Year	Problem	Hospital
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

FAMILY HISTORY:

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

Have any relatives had:

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Change in stool | <input type="checkbox"/> Prob with Intercourse |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Stuffy Nose | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Increased Urination | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Trouble Seeing | <input type="checkbox"/> at night | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Trouble Hearing | <input type="checkbox"/> Leg Pain w/ walking | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Numbness | <input type="checkbox"/> Enlarged Heart |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> when you lie down | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Nervous | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depressed | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> Decreased Appetite | <input type="checkbox"/> Urinary Tract |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Weight Change | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Pain with Urination | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Frigidity |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Dark Stool (black) |
| | <input type="checkbox"/> Change in bowel habits | |

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	<input type="checkbox"/>
EKG?	Yes	When? _____	Where? _____	No	<input type="checkbox"/>
Chest X-Ray?	Yes	When? _____	Where? _____	No	<input type="checkbox"/>

WOMEN ONLY

MENSTRUAL HISTORY:

Do you have any menstrual problems? Yes No

- | | | |
|------------------------------|--|---------------------------------|
| Date of last period? _____ | <input type="checkbox"/> Heavy Periods | Other menstrual problems: _____ |
| Frequency of periods? _____ | <input type="checkbox"/> Irregular Periods | _____ |
| Date of last PAP? _____ | <input type="checkbox"/> Painful Periods | _____ |
| Number of Pregnancies: _____ | <input type="checkbox"/> Spotting | _____ |
| Number of Deliveries: _____ | | |

Signature of Patient: _____

Date: _____

Form Reviewed by: _____

Date: _____



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 #
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CONTACT NAME	RELATIONSHIP	TELEPHONE #
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PRINT NAME

PATIENT'S SIGNATURE

DATE