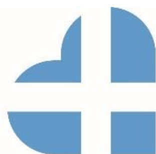


Anderson Free Clinic

Providing Better Health Through Caring

NEW PATIENT AND RE-CERTIFICATION APPLICATION

NEW PATIENTS: Please complete application and return during regular business hours or call to schedule an initial screening. The last page contains the list of required documents. The complete process for new patients may take 1-2 weeks.

Anderson Free Clinic 864-226-1294 or 864-512-7804, 414 N. Fant St. Anderson SC 29621
Honea Path Free Clinic 34 N. Main St. 864-369-9493

ALREADY A PATIENT: Each year, please complete application, bring required documents and check in at front window during regular business hours to meet with intake coordinator. Be aware that processing may take up to one week.

Office use only:

Epic#__________________

CALL BACK INFO:
Date:
Response:
1.

2.

3.

☐ **New Patient Application** ☐ **Recertification**

SECTION 1: PATIENT CONTACT INFORMATION

LAST Name:	First Name:	M:
Address:		
City:	State:	Zip:
Phone (cell):	Phone (home):	
Social Security #: - -	Birth Date:	Male ☐ Female ☐
Emergency Contact:	Phone:	Relationship:
Primary Language:	Do you need an interpreter? (circle):	YES NO

SECTION 2: INCOME AND INSURANCE QUESTIONS

Number of people in your household, including you: _________

1. ___________________________Relationship to you_______ 2. _______________________________ Relationship to you_______

3. ___________________________Relationship to you_______ 4. _______________________________ Relationship to you_______

EMAIL: ____

Housing Status: (Check which one applies):

☐ Own ☐ Rent ☐ Friend/Relative ☐ HUD/Section 8/Public Housing
☐ Shelter ☐ Haven of Rest ☐ Homeless ☐ Other – please name ___________________________

Do you have medical insurance from any of the following: (Check all that apply)
☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ VA/Military

Marital Status	Education Level	Race/Ethnicity	Employment Status
☐ Single	☐ Grade School	☐ White/Caucasian	☐ Employed Full Time
☐ Married	☐ Some High School	☐ Black/African American	☐ Part Time or Temp
☐ Divorced	☐ High School Graduate	☐ Hispanic	☐ Retired
☐ Widowed	☐ GED	☐ Native American	☐ On Social Security Disability
☐ Separated	☐ Some College	☐ Asian	☐ Unemployed since
☐ Partner	☐ College Graduate	☐ Other ______________	__________________ Month / Year

Total MONTHLY household Income: (please list ALL income for ALL members of your household listed above)

Salary/Wages: ______________ (you) ______________(spouse) ____________(other)
SSI/SSA or Pension /Benefits: ___________(you)_________(spouse) _________(other)
Child Support: __________ Alimony ____________
Housing Allowance: __________
Unemployment: _____________
Food Stamps: ___________

To be completed by AFC:

HH SIZE: ______ Total Income: _____________ ELIGIBLE: _____ CERT Expires: _________________
Screened By: _________________________________ on (date) _______________________

Office use only:

Epic#_________________

CALL BACK INFO:
Date:
Response:
1.

2.

3.

SECTION 3: MEDICAL INFORMATION

Please check if you have any of the following conditions:

☐ Diabetes	☐ COPD (lung disease)	☐ Dental Problems	☐ Excessive Thirst
☐ Asthma	☐ Congestive Heart Failure	☐ Excessive Urination	☐ Seizures
☐ Cancer	☐ Heart Disease	☐ Stroke	☐ Arthritis
☐ Chest Pain	☐ Shortness of Breath	☐ HIV/AIDS	☐ Kidney Disease
☐ Mental Illness	☐ High Blood Pressure	☐ Heart Attack	☐ Hepatitis
☐ Sleeping Problems	☐ Fast weight circle loss or gain	☐ Constant muscle pain	☐ Blurry Vision

☐ Pain, Numbness, and tingling in the arm, wrist, hand, or fingers
☐ Change in urination like: difficult urinating, holding back urine, slow urine flow

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

____
____
____
____

****ALLERGIES****

____
____

☐ I HAVE NO KNOWN DRUG ALLERGIES

Smoking/Tobacco use:

☐ I have never smoked/used tobacco
☐ I quit using tobacco _______ years ago
☐ I currently smoke or use tobacco products (pipe, cigar, etc.)
packs per day __________ how many years_________

Medical history (Circle any conditions the following family members have had):

Mother	Father	Sibling(s)	Maternal Grandparent	Paternal Grandparent
Cancer	Cancer	Cancer	Cancer	Cancer
Diabetes	Diabetes	Diabetes	Diabetes	Diabetes
Heart Attack	Heart Attack	Heart Attack	Heart Attack	Heart Attack
Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart disease
High BP	High BP	High BP	High BP	High BP (BP=Blood Pressure)
Stroke	Stroke	Stroke	Stroke	Stroke
Respiratory	Respiratory	Respiratory	Respiratory	Respiratory (problems)
Don't know	Don't know	Don't know	Don't Know	Don't know

Were you hospitalized in the past 6 months? YES /NO

Name of Hospital: ____________________________
Reason: ____________________________________

Other health concerns:

SECTION 4: CERTIFICATION

I_______________________________________, certify that the above information is correct. I understand that completing this application does not guarantee I will be eligible for Anderson Free Clinic services. **I understand that providing false or incomplete information, or failing to notify the clinic of change in household income or insurance status may result in my dismissal from being a free clinic patient.**

X____ ____________________
Patient Signature **Date**

SECTION 5: Patient Responsibilities:

Please initial next to the following, indicating that you have read, understand and agree to the following consequences should you fail to comply with the following responsibilities:

______ **BEHAVIOR:** Patients are expected to behave appropriately while on free clinic property or at any other
Initials location associated with the free clinic. Engaging in any of the following **UNACCEPTABLE BEHAVIORS** will result in my immediate dismissal from the Anderson Free Clinic:

- ☐ Any act of Violence, rude and disruptive behavior, verbally threatening or intimidating staff, volunteers, or other free clinic patients
- ☐ Bringing weapons of any kind onto Anderson Free Clinic property
- ☐ Using or possessing illegal substances on Anderson Free Clinic property
- ☐ Discriminating against Staff/Volunteers/Others on the basis of Race, ethnicity, gender, national origin, religious affiliation, or sexual orientation
- ☐ Damaging, littering, or showing disrespect to, or smoking on AFC property
- ☐ Using profanity, yelling, or otherwise exhibiting rude/disruptive behavior
- ☐ Failing to adhere to the agreed-upon treatment plan or providing false information about previous medical care
- ☐ Arriving intoxicated on Free Clinic property
- ☐ Attempting to contact our Volunteer Physicians or referral doctors at their private practices or outside the context of the Free Clinic
- ☐ **Requesting prescriptions for controlled substances**
- ☐ **Asking AFC providers to fill out Disability forms or other paperwork certifying medical conditions**
- ☐ Engaging in disruptive or disrespectful behavior during a referral appointment or otherwise violating the Free Clinic Physician Referral Policy
- ☐ Failing to recertify with the Intake Coordinator on an annual basis or as requested

______ **PHARMACY:** Pharmacy hours are Mon-Thurs 9am-3pm Fri 9am-12pm. Failure to meet the following guidelines
Initials may result in temporary or permanent lack of access to medications:

- ☐ Meet all deadlines to sign paperwork or turn in financial/insurance documents requested by the Patient Assistance Program Coordinator and required by pharmaceutical companies
- ☐ Failure to give our staff your most current phone and contact information
- ☐ Medications and refills for patients may take (2) BUSINESS days to be processed.
- ☐ Pharmacy will not give medications without a valid prescription. If out of refills, the patient MUST be seen by an AFC medical provider for a prescription to be written and filled
- ☐ Refills are written at provider discretion and may be subject to requested labs and tests

______ **FEES:** I understand that I am responsible for all services that are not covered as a patient here at the free clinic. It is my responsibility to find out all costs associated with outside services. Additionally, I am responsible for paying Free Clinic and Pharmacy fees which include the annual $20 recertification fee and the $2 per medication charged by the pharmacy.

X____ ____________________

Patient Signature **Date**

SECTION 6: No Show, Lab and Referral Policy Agreement

It is expected that all patients arrive on time for appointments and come prepared BRING ALL MEDICATION BOTTLES. Lab work must be done at least 2 weeks prior to your appointment date.

1. If I arrive more than 15 minutes late for any appointment, my appointment will be cancelled and I will be counted as a NO-SHOW.
2. CANCELLED APPOINTMENTS may be rescheduled by leaving a message at (864) 512-7804 with Patient Name and date of birth. **Appointments must be cancelled at least 24 hours in advance.** AFC has the right to refuse to reschedule repeated cancellations, regardless of the reason for cancellation.
3. OTHER REASONS FOR NO-SHOWS include 1) showing up for any appointment without all of my medications in original bottles and/or 2) failing to complete lab tests within at least two weeks of my scheduled appointment 3) failing to complete radiology orders.
4. If you show up for an appointment INTOXICATED/Under the influence of Alcohol or Illegal substances, you will be NO-SHOWED for the appointment, requested to leave the premises, and given a formal warning of dismissal.

THE THIRD "NO SHOW" of an existing patient will result in suspension of medical, dental, and vision appointment privileges for one year from the date of the third no- show. Patients will be scheduled at the end of the day, when an opening is available. Patients will still be able to use the pharmacy as long as they have refills. **Recurring No-Shows after 12 months suspension are grounds for dismissal.**

Anderson Free Clinic Physician/Dentist Referral Policy:

1. Appointments will be made by the Free Clinic staff and you will be notified by of the date and time
2. We CANNOT guarantee an appointment. Some physicians volunteer their time at their own practices to help Free Clinic patients who need care from a specialist, as per our referrals. **Patients who miss referral appointments with no cancellation calls may not get that appointment rescheduled.**
3. Medications prescribed by the referral provider can be filled at the Free Clinic pharmacy if we carry that medication or can obtain it. **If not**, it is the patient's responsibility to obtain the medication.
4. You MUST have your certification current at the Free Clinic to be eligible for a referral visit.
5. You must be seen first by a primary care physician and given a referral form which you must present at the time of your referral appointment in order to be seen
6. All free clinic policy regarding behavior and actions that are grounds for dismissal apply at any referral appointment or facility where labs are completed
7. It is YOUR responsibility to call the referral doctor's office if you need to cancel or reschedule an appointment. Appointments missed without YOU notifying the doctor's office may NOT be rescheduled.
8. Additional responsibilities may apply **depending on the referral office**. We have agreed to follow their individual guidelines and these may vary from office to office.
9. It is your responsibility to verify if there are any costs associated with your referral visit and you will be responsible for paying or seeking financial assistance for any bills related to referral appointments.

SECTION 7: Rights that I am Forfeiting

I understand that by receiving free care, I waive my right to take legal action against any and all medical and dental providers or ancillary personnel at this clinic or to otherwise seek a monetary recovery from Anderson Free Clinic and/or its employees and health care volunteers for any alleged professional acts of negligence, except for acts or omissions that are deemed to be grossly negligent or are considered willful and malicious, regardless of where such services are performed.

X____ ____________________

Patient Signature **Date**

SECTION 8: South Carolina Consent for Care

I am asking for care at this facility. I understand that upon becoming a patient of the Anderson Free Clinic I will receive services by one or more medical practitioners working without financial compensation and in good faith. I agree to receive medical services voluntarily and without compensation, expectation, or promise thereof; these medical services will be rendered by medical providers volunteering their service associated with Anderson Free Clinic. I agree to permit the medical provider and other caregivers associated with Anderson Free Clinic to treat me in ways they judge beneficial to me. I understand that this care may include tests, examinations, medical and/or surgical treatment. No one has given me any guarantee of how these examinations and treatment will affect my condition or me. This acknowledgement or agreement has been made prior to the rendering of medical services by the medical provider.

X____ ____________________

Patient Signature **Date**

RELEASE AND RETREIVAL OF INFORMATION TO PHARMACEUTICAL, AGENCIES, INDIGENT CARE PROGRAMS, AND VARIOUS REFERRAL PROVIDERS:

I provide consent/permission to Manufacturers Patient Assistance Programs or it's designees to review patient records (both eligibility and pharmacy) for auditing purposes. I also provide consent/permission to share biographical, including facts related to my health, and financial information with other agencies, pharmaceutical companies, indigent care programs, and various referral providers to better find and secure the appropriate care, medication, and/or treatment.

I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO PROVIDE ANY INFORMATION UPON REQUEST, BUT IN SO DOING I UNDERSTAND THAT THIS MAY ALSO LIMIT THE RESOURCES/SERVICES AVAILABLE TO ME.

X____ ____________________

Patient Signature **Date**

MEDICAL INFORMATION RELEASE TO INDIVIDUALS REGARDING MY HEALTH/ EMERGENCY CONTACT

Upon signature below: *(Choose one by checking below)*

☐ **I AUTHORIZE AFC** to leave messages or speak with the following person(s) regarding appointments, diagnosis, records, and/or examination rendered to me while I am an established patient of the Free Clinic:

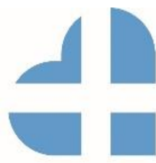
Name: _____________________________________ Relationship: _______________ Phone: ______________________

Name: _____________________________________ Relationship: _______________ Phone: ______________________

☐ **I DO NOT AUTHORIZE AFC** to speak with anyone else regarding appointments, diagnosis, records, and/or examination rendered to me while I am an established patient of the free clinic.

X____ ____________________

Patient Signature **Date**



Anderson Free Clinic

Providing Better Health Through Caring

NO INSURANCE FORM

-Proof of NO Insurance coverage-

Patient Section

I, ______________________________________ declare that I/nor anyone else has third party insurance coverage on me.

I____ declare I am not eligible for Medicare/Medicaid at this time

X____ __________________

Patient Signature **Date**

X____ __________________

AFC Staff member Signature **Date**

NO INCOME FORM

-This form is only to be used if there is NO household income-

Patient Section

I, ___________________________________ declare that I and no one living in my household have any income,
(Printed name)
Including but not limited to wages, payment for odd jobs/cash payment, pensions, or other income. If I or anyone in my household receive assistance from SNAP (Food Stamps) and or the Housing Authority (HUD), I have attached proof of the amounts I receive from these assistance programs.

X____ ____________________

Patient Signature **Date**

****Supporter Section****

Name: ___________________________ Phone number: __________________________

What is your relation to the Patient? : ___________________________

Do you live in a residence with the above signed patient? (Circle) YES NO

If YES, how long has the patient lived in the same residence with you? ______________________

If AFC determines that this person is part of the patient's household they must also provide proof of their income.

I, ___________________________________ support the above mentioned person with the following monthly
(Name of person helping patient)
Amounts (if the answer is $0 for any of the following please state why and how the patient is able to pay for these):

$______ Food (if $0 state why/how): ____

$______ House/Rent (if $0 state why/how):____

$______Utilities (if $0 state why/how): ____

$______Medication (if $0 state why/how):____

$______Transportation (If $0 state why/how):_______________________________________

Total: $______

By signing below, I verify the above patient's current living situation and that ALL the above information is true.

X____ ____________________

Supporter Signature **Date**

PATIENT APPLICATION DOCUMENTS NEEDED

NAME:____________________________________DOB:_____________________

_____ **$20.00 Certification Fee** – Cash, check or money order

_____ Medicaid Denial Letter (Form 3300) from DSS office located at **224 McGee Rd. Anderson, SC 29625**

_____ SNAP letter (food stamp letter) from DSS office located at **224 McGee Rd. Anderson, SC 29625**

_____ Valid South Carolina driver's license or photo ID, passport, employment card or permanent resident card – **CANNOT BE EXPIRED**

_____ Social security card or document with social security number printed on it or letter from DHHS showing a replacement card has been applied for

_____ **Proof of income for 1 month** – current pay stubs, retirement income statement, W2 forms, last year's tax return or other income documentation for **you and every person living in your household** ***(self-employed applicants will submit- SELF DECLARATION OF EMPLOYMENT FORM)***

_____ Signed support form – letter signed by the person(s) who provides you with financial or living assistance stating what they do for you – housing, utilities, groceries, etc. PLEASE INCLUDE THEIR NAME AND CONTACT PHONE NUMBER

_____ Proof of residence – written proof that you live at the address listed on your application – utility bill, lease agreement, bank statement, junk mail, etc.

_____ Proof of NO insurance – letter from employer, on company letterhead, stating that insurance is not provided or listing the amount it would cost you to obtain insurance through your employer

ANDERSON FREE CLINIC 414 N. FANT ST ANDERSON, SC 29621

(864)226-1294 OR (864)512-7804

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name / DOB: _________________________ Date___________

TO: Anderson Free Clinic

414 N FANT ST.

ANDERSON, SC 29621

I authorize the clinic to release my information to: **Direct Relief, Merck and Pfizer**

for the purpose of: ________________.

Signature _______________________ Signature______________________

(Patient) (Witness)