Notice to Patients

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after 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, board member, officer, employee, or independent contractor who 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, board member, officer, employee, or independent contractor 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)).

The above 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.

Acknowledged:

(Patient signature)

(Patient name, printed legibly)

Date

Acknowledgement of Review of Notice of Privacy Practices- HIPAA

I have reviewed this Clinic's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient, Parent, Guardian or Personal Representative

Date
### INCOME DECLARATION AND FRAUD STATEMENT

**Today's Date/Fecha de Hoy:**

<table>
<thead>
<tr>
<th>Patient Name/Nombre de Paciente</th>
<th>Social Security/Número de Seguro Social</th>
</tr>
</thead>
</table>

### Income Screening Tool

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Amount</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Household Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number in HH (Include dependents claimed on tax return)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screener's Initials</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Fraud Statement

I, __________________, do hereby affirm that the income I have declared is correct and can be verified if necessary.

- If my income should change, due to loss of job, new employment or income received from any source, I agree to report the change to the clinic where I receive health care.
- I understand that failing to report employment or income from any source could result in civil or criminal penalties. I may also be held responsible for full payment for any medical services received at the clinic.
- I understand that if I am under the age of 19, I may declare myself a household of one person and claim my own income for Family Planning services.

Yo, __________________, afirmo que el ingreso declarado es el correcto y puede ser verificado si es necesario.

- Si mi ingreso llegaría a cambiar, dado a pérdida de trabajo, nuevo empleo o recibido de otra fuente, Yo estoy de acuerdo en reportar estos cambios a la clínica en la cual recibo atención médica.
- Yo estoy consciente que no reportar empleo o ingresos de cualquier fuente puede resultar en cargos penales civiles o criminales. También estoy consciente que puedo ser responsable por los cargos médicos de los servicios recibidos en la clínica en su totalidad.
- Estoy consciente que sí soy menor de 19 años, yo puedo declararme como la cabeza de familia de uno y declarar mis ingresos para los servicios de Planificación de Familia.

### Signatures

<table>
<thead>
<tr>
<th>Printed Name/Nombre Escrito en Moldé</th>
<th>Date/Fecha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Signature/Firma de Paciente</td>
<td>Witness Signature/Firma de Testigo</td>
</tr>
</tbody>
</table>

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Patient Name______________________________ Date of Birth________________

What is the one concern you are here to be seen for today? __________________________________________________________

On any medicines currently? What dose? How many times a day? How long have you been on it?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Are you allergic to any medicines? What type of reaction?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Are you allergic to latex (balloons, rubber gloves, etc.)? _______________________________________________________

Do you have any food or nut allergies? __________________________________________

Have you been hospitalized in the past or had surgery? When? Reason?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Any ongoing medical problems?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Major medical problems in your family? Who?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you smoke/what do you smoke? How many per week?

________________________________________________________________________

Do you drink alcohol/what? How much per week?

________________________________________________________________________

Office use only: Info in EMR ______