SRCC Patient Intake & Required Waivers

DATE: _____

Name _____
LAST FIRST MIDDLE INITIAL

Parent/Legal Guardian's Name if Minor: _____

Address _____

Address (cont) _____

City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Sex (circle one) Female Male

OTHER NAMES USED: _____

Are you married: ____YES ____NO SSN _____

Home Phone _____ Mobile Phone _____

Emergency contact: _____ Relationship to you _____

Emergency Phone _____ Consent to Text (circle one): Yes No

Email _____ Consent to Email (circle one): Yes No

WHAT IS THE REASON YOU ARE HERE TONIGHT? (print neatly and be brief) _____

_____

_____

MONTHLY HOUSEHOLD INCOME: _____ HOUSEHOLD SIZE (number of people in household): _____

We MUST have proof of household income by your 2nd visit of the year.

Where would you go for services if SRCC was not available: _____

YOUR PRIVACY

This clinic and all of its volunteers are dedicated to protecting your confidential information. You have the right to request your records, amend your records, restrict health information disclosures, and receive a copy of health information disclosures made. We need your permission to give information to a family member, legal representative, or designated agent. We will not need your permission to use your information for treatment or services, including continuity of care review.

I have read and understood this confidentiality policy: _____
Patient's Signature

WAIVER of LIABILITY – MUST BE SIGNED

Immunity from Liability for Health Care Providers Providing Charitable Medical Care – Idaho Code: 39-7703.

The above law says that our free clinic's health care Providers, who voluntarily and without pay or expectation of being paid, provide you with medical or health care services at our clinic because you cannot afford to pay, are protected from being sued for ant civil Court action that comes about from them and our clinic providing you with needed medical or health services. This law for any Intentional, willful, or grossly negligent acts does not protect us or if one of us provides a medical service outside of our licensed, Certified, or registered scope of practice. This includes parents and/or guardians signing for a minor.

I have read and understood this waiver of liability: **Patient's Signature**_____

Patient Notice of Limited Liability of FTCA Deemed Volunteer Free Clinic Health Care Professionals

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 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 the above Federal law.

I have read and understood these waivers of liability: _____ **DATE:** _____
Patient's Signature