Welcome to Healing Grace Clinic!

We are a clinic that provides medical care to patients without health insurance. Following the tradition of Jesus Christ, our mission is to promote health physically, emotionally and spiritually to those who attend here.

Hours: Wed/Thurs: 8:30 am-4:00pm
Sat: 9:00am-12:00pm
Closed some Saturdays: please call for further info

WHAT WE PROVIDE:

- **Office visits** where you may be seen by a licensed nurse practitioner, physician assistant or physician ($10.00 donation is requested at each visit)
- **Free eye exams** with a licensed optometrist at our Eye Clinic
- **Free radiology testing**, courtesy of St. Luke's RAYUS radiology (x-rays, MRI, CT)
- **Free mammograms** through "Show Me" Healthy Women grant at SSM St. Clare Hospital
- **Free lab testing**, courtesy of St. Luke's Hospital (conventional lab work)
- **Prescriptions:**
  - We attempt to write for prescriptions in the $4-$10 range
  - If they fall out of this range, discounts (and even free medications), may be available
- **Referrals** to other specialist providers, as needed and available, at no cost or reduced fees

PATIENT RESPONSIBILITIES:

- **Provide honest income assessment**. Our resources are limited. Please do your part in helping us provide for the patients with the most need. *Yearly income verification required.*
- **Be on time for your appointments.** If you are more than 15 minutes late, your appointment may need to be re-scheduled.
- **Avoid missed appointments.** Please call if you are unable to make your scheduled appointment. *After 3 "no-shows" either at clinic and/or at a referring specialist without any communication, you may receive a termination letter and we may no longer see you as a patient.*
- **Inappropriate words or actions.** The clinic is staffed mostly by volunteers. Words or actions seen as abusive, off-color or otherwise inappropriate will not be tolerated and may serve as reason for dismissal from the clinic at any time.

If you have any further questions, please do not hesitate to ask. We look forward to partnering with you in your journey to good health - ***TOGETHER WE WIN!***

HEALING GRACE CLINIC
-Financial Declaration-

To be seen as a patient at Healing Grace Clinic, you must have:

- No health insurance
- Limited income

The purpose is to make sure that the limited resources available are given to those with the most need. The following is required ***prior to*** your first visit and ***yearly*** thereafter.

REQUIREMENTS TO QUALIFY:

Identification

- Valid photo ID
- Social Security Number

Taxes - Current or last year – From BOTH YOU AND YOUR SPOUSE/SIGNIFICANT OTHER:

1. Taxes must be complete, signed and unaltered.
2. If self-prepared, include letter of acceptance by the IRS
3. *If you did not file taxes last year*, please provide ***both***
   a. "Verification of Non-Filing" letter from the IRS by
      - calling them at 1-800-829-1040 and follow the prompts OR
      - going to www.irs.gov and click on "Get a Transcript of Your Tax Records" under "Tools"
   b. Two most recent pay stubs or your most recent bank statement

Income limit is based on the size of your family. Family includes you, your spouse/significant other and your dependents who live with you. The annual income limit is based upon ***January 1, 2023*** allowances.

FAMILY OF	ANNUAL INCOME OF NO MORE THAN
1	$40,770
2	$54,930
3	$69,090
4	$83,250
5	$97,410
6	$111,570

Please circle the number of people living with you ***and provide most current tax forms for BOTH you and your spouse/significant other.***

By signing below, I am declaring that I do not carry any health insurance and that my household income level is below the limits as stated above. I understand that if the household income is found to be above what is stated or if I am found to have health insurance, I will be dismissed from care at Healing Grace Clinic.

_____ _____

Print Name Birthdate

_____ _____ _____

Signature Social Security Number Date

_____ _____ _____

Spouse/Significant Other's Name Social Security Number Date

Revised March 2023

HEALING GRACE CLINIC
HEALTHCARE FOR THE UNINSURED

How did you hear about us?: _____

Patient: _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____ **SS #:** _____

Address: _____ _____ _____
(City/State) (Zip Code)

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
May we leave a message? Y N May we leave a message? Y N May we leave a message? Y N

E-mail address: _____ **Gender: M F** **Marital Status: M W D S**

Employment status: FT PT Unemployed

Race (please circle): American Indian/Alaskan Native Black or African American Other Race Decline to report
Asian White Hispanic

Ethnicity: Hispanic Non-Hispanic Decline to report

Patient Authorization for the Disclosure and Usage of Protected Health Information (P.H.I.)
Acknowledgement of Notice of Privacy Practices

I, _____, understand that Healing Grace Clinic is authorized by me to use or disclose my protected health information for a purpose not other than, payment or health care operations. I have read the "Notice of Privacy Practices" overview and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.

I specifically authorize any current employee or volunteer of Healing Grace Clinic, or any other individual listed below to disclose my protected health information. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

I further understand that I retain the right to revoke this authorization through a signed and updated copy of another P.H.I. Permission Authorization.

Contact Information:

We may speak to or leave messages with the following people about your medical care/test results. ***Please list emergency contact first***:

Name Phone Relationship

_____ - **Emergency Contact**

_____

_____

_____

By signing this form, I agree that the above information is true and accurate to the best of my knowledge. I also agree to the authorization as stated above.

_____ _____
Signature Date

Pharmacy Name: _____ **Pharmacy Phone:** _____

HEALING GRACE

NOTICE OF PRIVACY PRACTICES

HIGHLIGHTED OVERVIEW

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully. A full version of the Notice of Privacy Practice is available at your request.**

Your Rights

You have the right to:

- Inspect and get a copy of our health record in paper format
- Request an amendment to your paper record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- Receive notification in the event we inappropriately disclose your information
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide continuity of care by accessing/sharing your medication history with a health exchange
- Market our services
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with the medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

By signing below, I agree with the above:

_____ **Date:** _____

Print Name

_____

Signature

HEALING GRACE CLINIC
New Patient Intake

Name: _____ **Date of Birth:** _____ **Date:** _____

MEDICAL PROBLEMS YOU WOULD LIKE HELP WITH (List):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

OTHER PAST MEDICAL PROBLEMS (List):

_____
_____
_____
_____
_____

SURGERIES (List):

_____
_____
_____
_____
_____

ALLERGIES (List and include reaction):

_____ _____
_____ _____
_____ _____
_____ _____

CURRENT MEDICATIONS (List):

Name	Dosage	# times/d	Name	Dosage	# times/d

LIFESTYLE/SOCIAL HISTORY:

Do you have a place to live?	No	Yes		
Problems getting food?	No	Yes	# meals daily: _____	
Problems with transportation?	No	Yes	*(circle)* Doctor appts	Other
Do you feel emotionally supported?	No	Yes	By whom? _____	
Are you involved with a church/club?	No	Yes	Name:? _____	
Do you feel safe at home?	No	Yes	Guns in the home? No	Yes

Tobacco use:	No	Cigarettes	Chew	Vapor	>100 cigarettes in lifetime?
Alcohol:	No	Beer/wine	Liquor		Amt Weekly: _____
Street Drugs:	No	Type: _____			Amt Weekly: _____
Caffeine:	No	Coffee	Tea	Soda	Amt Daily: _____
Seat belt use?	No	Yes	Guns in home?		No Yes

FAMILY HISTORY: Adopted? No Yes

Heart Attack	Diabetes	Cancer: Breast: Mom or Sister? Yes
Stroke	Thyroid Disease	Lung
High Blood Pressure	High Cholesterol	Prostate
Other: _____	Other: _____	Other type: _____

PREVENTATIVE CARE HISTORY

Tetanus Shot in past 10 years?	**No**	**Yes**
Pneumonia Vaccine?	**No**	**Yes**
Hepatitis A Vaccine?	**No**	**Yes**
Hepatitis B Vaccine?	**No**	**Yes**
Eye Exam in the past year?	**No**	**Yes**
Dental in the past year?	**No**	**Yes**

For Women Only (if applies):
Last Mammogram date: _____ Normal Abnormal
Last Pap Smear date: _____ Normal Abnormal

REVIEW OF SYSTEMS (Circle any that apply):

General: fever, weight loss, weight gain, fatigue, headache
Skin: rash, change in mole
Eyes: vision changes, redness, drainage, pain
ENT: hearing loss, sinus pain, difficulty swallowing, hoarseness
Allergy: sneezing, itchy/watery eyes, runny nose
Respiratory: cough, wheeze, colored sputum
CV: chest pain, shortness of breath, palpitations, swelling of feet
GI: nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain
GU: frequent urination, pain with urination, losing urine when you do not want to

FOR MEN:	urinating more than 2 x at night?	No	Yes		
FOR WOMEN:	date last period: _____	Sexually active?	No	Yes	
	abnormal bleeding:	No	Yes		
	new partner since last pap?	No	Yes		
	chance of pregnancy now?	No	Yes		
	breast concerns?	No	Yes		

MS: loss of motion, swelling, pain- where? _____
IF PAIN, HOW MUCH DOES IT AFFECT DAILY ACTIVITY Min. Mod. Severe
Neuro: tingling, lack of feeling in extremity, weakness, dizziness, speech problems

----------PLEASE STOP HERE!!----------

WT: _____ HT:_____ T: _____ P: _____ R: _____ BP: _____ Repeat BP: _____
Peak flow: _____ _____ _____ Expected:_____

EXAM:

Gen: A & O, NAD _____
Skin: No abnormal lesions, rashes _____
Eyes: PERRLA. EOMi. Non-icteric. No abnl drainage. _____
HEENT: Atraumatic. TM's/canals clear B. No NC or sinus tend. _____
Lips, teeth, gums, oropharynx WNL _____
Neck: FROM. No thyromegaly. No tenderness. No adenopathy _____
Heart: RRR without murmur or gallop. No edema. _____
Lungs: BS WNL. No wheezes, rales or rhonchi. _____
Abd: NABS. Percussion WNL. No HSM. No tend./mass/bruit. _____
MS: FROM. No deformities or discoloration. _____
Neuro: CN II-XII intact. Strength 5/5 B =. 2+/4+ DTR's B =. _____
Psych: Cooperative. Mood and affect WNL. Judgment/insight _____
good. No tremor/fidgeting. Memory grossly WNL. _____

ORDERS: *(please mark)*

O Labs: O CBC with dif O CMP O TSH rflx FT4/3 O FLP O U/A rflx micro or cult
O Hgb A1C O BMP O T4, Free O LP O Urine microalbumin
O Radiology Study: _____ O Contrast O No contrast
O Dx: _____ O Acute O Chronic
O New Patient Packet (vaccination recommendations, vision/dental resources)
O PT Eval and Tx for _____ x 1 visit (release 6 more once eval received)
O Other: _____

(cont'd)