



## 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, courtesy of the Eureka Lions Club, Midland Optical and Essilor.
- **Free radiology testing** (x-rays, MRI, CT) courtesy of St. Luke's RAYUS.
- **Free Mammograms** through the "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.
- **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. Missed appointments or overdue lab work/appointments may cause a delay in prescription refills. *After 3 "no-shows" either at clinic and/or at a referring specialist without any communication, you will receive a termination letter and we will 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 1-800-908-9946 and follow the prompts OR
    - going to [www.irs.gov](http://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. Annual household income must be equal to or less than 300% of the ***January 1, 2026*** Federal Poverty Limit.

FAMILY OF	ANNUAL INCOME OF NO MORE THAN
1	\$46,950
2	\$63,450
3	\$79,950
4	\$96,450
5	\$112,950
6	\$129,450

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

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse/Significant Other’s Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date



How did you hear about us? \_\_\_\_\_

## Patient

\_\_\_\_\_  
(First Name) (Middle Name) (Last Name)

Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_

Sex(circle):      Male      Female      Decline to comment

Marital Status:      Married      Divorced      Widowed      Single

Employment status: FT      PT      Unemployed

## Demographics

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

Preferred Language: \_\_\_\_\_

## Contact

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City/State) (Zip Code)

E-mail address: \_\_\_\_\_

Preferred method of communication (circle):      Mobile Phone      Home Phone      Work Phone

May we leave a message?      Y      N

By signing this form, I agree that the above information is true and accurate to the best of my knowledge and agree to the authorizations above. This form is to be reviewed and update on an annual basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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 at a later date.

**Contact Information:**

We may speak to or leave messages with the following people about your medical care/test results.

***Please list emergency contact first:***

<i>Name</i>	<i>Phone</i>	<i>Relationship</i>
_____	_____	_____

Other Contacts:

<i>Name</i>	<i>Phone</i>	<i>Relationship</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing this form, I agree to the authorization as stated above. This authorization is to be renewed yearly.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**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:**

\_\_\_\_\_

**Print Name**

**Date:** \_\_\_\_\_

\_\_\_\_\_

**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? _____
Involved with a church/club?	No	Yes	Name: ? _____
Do you feel safe at home?	No	Yes	

**Tobacco use (circle):**

Non-smoker	Ex-smoker/chew	quit >5 years ago?	Y	N
Light cigarette smoker (1-9 cigs/day)				
Moderate cigarette smoker (10-19 cigs/day)				
Heavy cigarette smoker (20-39 cigs/day)				
Very heavy cigarette smoker (40+ cigs/day)				
Electronic/Vape user	Chew tobacco	Cigar smoker	Pipe smoker	

**Alcohol use (circle):** Never Monthly or less 2-4/month 2-3/week 4 or more/week

**How many standard drinks containing alcohol do you have on a typical day (circle)?**

0 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

**How often do you have 6 or more drinks on 1 occasion (circle)?**

Never Less than monthly Monthly or less Weekly Daily or almost daily

**Recreational Drugs:** No Type: \_\_\_\_\_ Amt Weekly: \_\_\_\_\_

**Caffeine:** No Coffee Tea Soda Amt Daily: \_\_\_\_\_

**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

**Shingles Vaccine?** No Yes

**COVID Vaccine?** No Yes

**Eye Exam in the past year?** No Yes

**Dental in the past year?** No Yes

**For Women Only:**

**Last Mammogram** date: \_\_\_\_\_ Normal Abnormal

**Last Pap Smear** date: \_\_\_\_\_ Normal Abnormal

**Hysterectomy in past?** date: \_\_\_\_\_ due to cancer? Y N

### 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