Crescent Community Clinic

Application For Health Care

Please complete all information. Incomplete applications will delay approval for services.
If you received emergency room services at hospital(s) you may be redirected elsewhere for services.

Clinic is limited to providing chronic health care, palliative dental and mental health services.
The clinic is not a walk-in, acute care or emergency clinic. Patients must have appointments

Name _____ Date Of Birth _____ Place of Birth _____

Address _____ City _____ Zip _____

Telephone _____ Cell _____ Email Address _____

Single ☐ Married ☐ Divorced ☐ Primary Language _____ Education _____

Social Security Number _____ Driver's License Number _____

Emergency Contact _____ Phone _____

Pharmacy _____ Location _____ Phone _____

Signature of applicant _____ Date _____

CHECK*ALL* YOUR HEALTH CONDITION(S) Musthave a chronic health condition to receive services

Chronic Health

☐ Asthma ☐ Arthritis ☐ COPD ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Heart Disease ☐ Obesity ☐ Urology

Dental

☐ Oral Infection(s) ☐ Tooth Extraction(s) ☐ Filling(s)

Mental Health

☐ Diagnosed mental illness ☐ Counseling ☐ Therapy ☐ Medication Management

Within two weeks, you will be called for an appointment to finalize the application. You must provide proof of income. It may be either a W-2 form, previous or current year's copy of the first page only of tax return, Social Security income letter/statement, or letter from person supporting you.
You must meet the Federal Poverty Guidelines to be eligible for clinic services. YOUMUST SUBMIT A MEDICAID DENIAL LETTER when you come for your eligibility appointment. Go to www.myflorida.com/accessflorida (http://www.myflorida.com/accessflorida) to apply for Medicaid. You may receive a denial letter which is needed for PPA program.
I have read and completed the application to the best of my ability. I understand the disability and smoking policies.
Mail or bring application to: 5244 Commercial Way, Spring Hill, FL 34606. Do not fax application.

Signature of patient _____ Date _____

Consent for Treatment at Crescent Community Clinic

I hereby give my express consent for all present and future services, treatment and medications prescribed or provided to me by the Crescent Community Clinic volunteer professional staff.

I understand that certain procedures, treatment and other activities may be carried out by person(s) other than a licensed physician but such activities will be under the supervision and direction of a licensed physician.

In consideration of said present services and future services, treatment and medication received from the Crescent Community Clinic and without any other representation, promise or agreement oral or written, I hereby fully and completely release and discharge the Crescent Community Clinic and all parties in interest from claims, demand, grievances and cause of action of every kind and nature whatsoever, including but without limitation of the foregoing, all liability for damages or injuries of every kind, nature, description, known or unknown, permanent or otherwise, now existing or which may hereafter arise from or out of the above mentioned services, treatment or medications received at the Crescent Community Clinic in the State of Florida.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or any other medical or medically-related facility, medical information bureau or other organization or person that has any record or knowledge of me or of my health, to give Crescent Community Clinic any such information. I also authorize Crescent Community Clinic to dispense medical information to the aforementioned person, facilities and organization.

I have read and understand this consent and release. I also understand that I must re-certify each year to continue to be eligible for services.

I agree to the following policies and understand that I will be disqualified from receiving services for any of the following reasons:

- **Non-compliance with following the medical instructions provided, including attending health literacy programs on diabetes, smoking cessation, nutrition and other health issues, and/or failure to attend 'Tools to Quit' smoking cessation program within allowable time frame.**
- **Failure to notify the clinic when my financial status changes or failure to update my financial information yearly which will result in being ineligible for services**
- **Missed appointment without notifying the office. You must call 24 hours beforescheduled appointment. Message may be left on answering machine at 352-610-9916.**
- **Disrespecting staff**
- **If under the influence of alcohol or illicit drugs at time of appointment you will be asked to leave and will not be rescheduled. Your chart will be closed**
- **Missed lab test, lost lab voucher or script. You must go elsewhere for lab and self-pay.**
- **Failure to pick up diagnostic test voucher within 5 business days of issue.**
- **Failure to pick up Form 1032 for referral to partnering provider within 5 business days will result in loss of voucher and appointment with provider. Form 1032 must be completed and brought to provider or you will have to pay for the appointment**

Crescent Community Clinic does not receive federal or state funding and depends on donations to continue to provide services. Please budget your resources to donate at time of appointment. Thank you

Signature of patient_____ **Date**

Print Name **Date of Birth**

Are you under a physician's care now? Yes ☐ No ☐

Current physician's name **Date last seen**

Phone **Fax**

Address **City** **State** **Zip**

Current Medications (including over-the-counter)

Are you pregnant? Yes ☐ No ☐ Date of last period:

Do you have or had any of the following conditions?

Yes	No		Yes	No	
○	○	Diabetes	○	○	Heart Murmur
○	○	Epilepsy	○	○	Joint Replacement
○	○	Heart Disease Heart Disorder	○	○	Valve Replacement
○	○	High or Low Blood Pressure	○	○	Artery Stent
○	○	Obesity	○	○	Excessive or Prolonged Bleeding
○	○	Asthma	○	○	Positive for HIV AIDS
○	○	Arthritis	○	○	Anemia
○	○	Urology	○	○	Aneurysm
○	○	Emphysema/COPD	○	○	Hepatitis
○	○	Cancer	○	○	Rheumatic Fever
○	○	Pulmonology	○	○	Back or neck pain
○	○	Hypertension	○	○	Lactose Intolerant
○	○	Heart Disease			
○	○	Pacemaker			
○	○	Anxiety *	○	○	Liver Disease
○	○	Depression *	○	○	Taking Osteoporosis medication
○	○	Diagnosed Mental Illness*			

*(need further screening (limited counseling services)

ALLERGIES:

Any other medical condition not listed above, please explain below:

Patient Signature_____ Date

- Complete the release of health information form if you do not personally have copies of your medical records. If you have copies bring to Intake appointment.

CRESCENT COMMUNITY CLINIC
5244 Commercial Way, Spring Hill, FL 34606
Phone: 352-610-9916 Fax: 352-610-9915
AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION
Patient's Name: Date of Birth:
Previous Name(s):
Social Security #: Driver's License Number
I request and authorize _____ to release healthcare information for the patient named above
Address where patient records are available
_____
_____
Request and authorization applies to:
[ ] Healthcare information relating to the following treatment, condition, or dates:
_____
_____
[ ] All healthcare information
[ ] Other: _____
Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia non-specific urethritis, syphilis, VDRL, Immunodeficiency Syndrome, and gonorrhea.
☐ Yes ☐ No I authorize the release of my STD results, HIV/IDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these tests results to anyone.
☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient Signature _____ Date

Print Name

Reset Form Print this form