Volunteers in Medicine West County Clinic
119 Baxter Shops Street
Manchester, Missouri 63011
Phone 636-207-5970 Fax 636-220-4376

Patient Registration

Patient Name:____
Last First M.I.

Address:____
Street City State Zip Code

Home Phone:___________________________ Cell Phone:_____________________________

Work Phone:_______________________ Email Address:________________________________

SSN:______________________ Date of Birth: _____/_____/_______ Sex: M______ F______

Marital Status:_____ S _____M _____O Spouse's Name: ______________________________

Primary Doctor: ____________________________ Referred By:___________________________

Emergency Contact:

Name: ________________________________ Relationship: ___________________________

Phone#:_______________________________

Person Responsible for Bill: ____

Address if different from patient: ____

Employer Information:

Patient's Employer: ____

Spouse's Employer: ____

Please Sign and Date

____ ________________________

Signature Patient, Parent, or Legal Guardian Date

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Patient Health History

Name: ________________________________ Date: ______________________

1. What brings you to the clinic?
   ____
2. Please circle if you have a history of any of these conditions.

Asthma	Bronchitis	Pneumonia
Heart disease	High Cholesterol	High blood pressure
Rheumatic fever	Peripheral vascular disease	Diabetes
Frequent infections	Thyroid disorder	Bleeding disorder
Anemia	Stomach disorder	Lactose intolerance
Gall bladder disease	Hepatitis	Bowel irregularity
Prostrate disease	Incontinence	Sexual dysfunction
Menstrual irregularities	Sexually transmitted disease	Back problem
Arthritis	Osteoporosis	Gout
Seizure disorder	Migraine headaches	Anxiety
Depression	Chronic rashes	Cancer

Other: ____

If you circled any of these conditions, please explain:

____
____
____
____

3. Please list any hospitalizations or surgeries. Include the reason and the date(s).

____
____
____

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PATIENT MEDICATION WORKSHEET

Patient Name: ________________________________ Date: ____________________

Drug Allergies: _______________________________ DOB: ____________________

Pharmacy name/location: _______________________ Pharm. Phone: ______________

Current Medication	Dosage	When taken?	Prescribing physician

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Patient Responsibilities

We want your experience here to be one of warmth and caring, and we wish to help you get well and keep as healthy as possible. Here are important things to understand about VIM and the care we provide.
PLEASE INITIAL NEXT TO EACH STATEMENT TO INDICATE YOUR AGREEMENT AND UNDERSTANDING.

_____1. I understand that the medical care at VIM is provided by volunteer doctors, nurses and other caregivers; therefore appointment availability is based upon volunteer time and there may be delays, rescheduling or changes in whom I see.

_____2. I understand that the Clinic provides basic healthcare and may not be able to help with all my medication problems (i.e., specialist referrals are not always available, there may be times that the patient must pursue a referral on their own as directed, etc) or provide all the medications I need.

_____3. The physician may order tests to help him/her understand the cause of my illness or the progress I am making towards recovery. It is my responsibility to have the tests completed as directed. It is also important that I keep follow-up Clinic appointments to discuss the tests results with the doctor or to call the Clinic and inquire if results have been received.

_____4. I understand that my failure to keep an appointment denies another person access to care. Missing an appointment is called a “No Show”. Failure to notify VIM of a cancelled appointment less than 24 hours in advance will be deemed a “No Show”. After the second No Show, a letter will be sent to me with a warning that a 3rd No Show will result in a permanent discharge from the VIM Clinic.

_____5. If I am more than 15 minutes late for my appointment, I may not be able to be seen that day.

_____6. If I am referred to an outside specialist, it is my responsibility to make and keep that appointment and get directions. If I am unable to keep an outside appointment, I will cancel that appointment in a timely manner (at least 24 hours in advance) with the office of the specialist. If I miss the specialist appointment without proper notification to that office, it will count as a “No Show” for the VIM Clinic. In addition, the specialist may choose to refuse to provide me care in the future.

_____7. Orders for lab, radiology and other testing/diagnostic procedures require contacting the financial counselors in that facility’s business office. I understand it is my responsibility to follow through with that procedure.

_____8. I agree it is my responsibility to ask questions if I do not understand what the doctors and nurses say about my medical problems or treatment.

_____9. Medical History is an integral part of competent medical care. I will notify the Clinic any time I receive care or medications outside the VIM. My failure to notify the VIM of outside care or refusal to grant access to outside records may result in being discharged from the VIM Clinic.

_____10. I understand that I will be discharged from the VIM Clinic if I do not keep these arrangements or if I am discourteous to any volunteer.

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NO SHOW POLICY

We are a free medical clinic that cares for our patients with volunteer staffing.

VIM cannot allow patients to abuse out system.

You **MUST** notify us that you cannot keep your scheduled medical appointment within **72 hours** so that we can allow another patient to utilize this time.

Notice: **If a patient misses (no shows) two (2) or more scheduled medical visits without notification – we must terminate your medical care at VIM and refer you to another primary care provider.**

You will receive a letter from our CEO notifying you of these providers.

Please cooperate with our volunteers who give you their time and talents to care for your medical needs.

I (patients printed name) have received a copy for this policy and understand my obligations as stated above.

Patient Signature: ___________________________ Date: __________________

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Contact Preferences

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please check the boxes next to each method of communication you would like to use.

Home
- [ ] OK to leave message with detailed information
- [ ] Leave message with call-back number only
- [ ] OK to mail information to home address

Work
- [ ] OK to leave message with detailed information
- [ ] Leave message with call-back number only
- [ ] OK to mail information to work address
- [ ] OK to fax information to work fax

Cell Phone
- [ ] OK to leave message with detailed information
- [ ] Leave message with call-back number only

Other
The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. Please see the accompanying Notice of Privacy Practices for more information on our policies. Please list any individuals among your friends, family or caretakers with whom we are authorized to discuss your protected health information. You should write your spouse name here if he/she is authorized. This is optional; if you do not wish us to discuss your PHI with anyone but yourself and your healthcare providers, please leave this blank.

NAME	PHONE NUMBER	RELATIONSHIP

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

____ ________________________

Patient/Guardian Signature Date

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VOLUNTEERS IN MEDICINE WEST COUNTY: AUTHORIZATION TO UTILIZE UNENCRYPTED EMAIL TO COMMUNICATE PROTECTED HEALTH INFORMATION*

Electronic mail (email) forms of communication that may be used between you and the providers. We want to make sure you know that unencrypted email is not a secure communication. We do not have the ability to encrypt email communication of protected health information. Encryption is the process of making information unreadable unless you have the password or key to decrypt the information.

If you elect to communicate from your workplace computer, you should be aware that your employer and its agents might have access to email communications between us. Email and text communications may become a part of your patient medical record and be accessible to our clinical support staff as needed for our operations.

Incoming email communications will be reviewed and answered as soon as possible. If you have not heard from your provider's office with a response and are concerned that your message was not received, please call the office during regular business hours. EMAIL COMMUNICATION SHOULD NEVER BE USED IN THE CASE OF AN EMERGENCY OR FOR URGENT REQUESTS FOR INFORMATION.

ACCEPTED: Signature of Individual ________________________________Date_________

Printed Patient Name __________________________________ DOB ___/_______/_______

Authorized E-mail of Individual ____

*Please note, this form is valid for all entities and providers comprising Volunteers in Medicine West County.