425 Health Center Dr.
PO Box 1329
Nags Head NC 27959
Tel: 252-261-3041
Fax: 252-255-6352
www.dareclinic.org

PATIENT INFORMATION

Application for: ☐ Clinic and Medication Assistance ☐ Medication Assistance Only (must have primary care provider)

First Name ______________________ MI____________ Last ____________________________

Address ____________________________ City ____________________ State______ Zip_________

County ____________ Home Phone ______________ Cell Phone____________ Consent to text ☐yes ☐No

Birthdate ______________ Age: _____ Social Security Number ______________________

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced ☐Widowed

Race/Ethnicity: ☐Black/African American ☐White (not Hispanic or Latin) ☐Hispanic or Latin ☐Asian/Pacific Islander ☐Native American ☐Unknown

Do you live or work in Dare County? ☐Yes ☐No Are you a US Citizen? ☐Yes ☐No Are you a Veteran? ☐Yes ☐No

Do you speak English? ☐ Yes ☐ No Do you need an interpreter? ☐ Yes ☐ No

Total # of people in the household (including children): _____ # of Children in the Household: ______

Emergency contact name and phone# ____

Permission to call or leave message on your behalf? ☐Yes ☐No

Email for our patient portal? ☐yes ☐ No Email:______________________________

Are you currently employed? ☐ Yes ☐ No

<u>Please list all members that live in your household and income source (salary/ages, Social Security, Retirement, Unemployment, Food Stamps, Rental Income, Workman's Comp, Veteran's Benefits, etc.):</u>

Patient Name: ________________ Monthly Income: __________ Income Source: ______________

Name: ____________________ Monthly Income: __________ Income Source: ______________

Birthdate: ___________ Relationship: ____________

Do you have any of the following? Circle: Medicaid Medicare Medicare Part D VA Private/Employer Health Insurance

Note: 1) The Community Care Clinic does not provide pain management services. 2) If you need treatment for depression or mental health issues, contact Port Human Services at 252-441-2324. <u>WE DO NOT prescribe narcotics or controlled medications</u>.

Fraud Warning: You have requested services from CCC of Dare. This clinic provides health care and prescriptions to qualifying individuals. By signing this form, you attest that the information you have given is a true and complete statement of facts. Any questions answered incorrectly whether they are misunderstood or intentionally falsified may constitute fraud. Committing fraud will prevent you from receiving future health care and prescriptions through CCC of Dare and will result in your being responsible for payment of fees.

Patient Signature: ________________________________ Date: ___________

MEDICAL RECORDS RELEASE/ HIPPA DISCLOSURE AND CONSENT FOR TREATMENT

Community Care Clinic
Of Dare
425 Health Center Dr.
Nags Head, NC 27959
252-261-3041
F 252-255-6352

Patient Name____DOB____________________

Social Security______________________________Telephone____________________________

I, authorize: Community Care Clinic of Dare (CCCCD) and/or Albemarle Project Access (APA)

To Release/Obtain: □ My entire medical record for all dates of all services inclusive of any drug, financial or health information.

You are hereby authorized to furnish all my protected health information to:

□ Facility to receive/obtain information____

□ Spouse______________________________________ □ Child______________________________

□ Legal Guardian, POA:-----------------------------------

□ Primary Care ---

□Other ------------------------------------

This information is being disclosed for the following purpose:__________________________

____

I understand that:

- I may revoke this Authorization at any time:
  The revocation will not apply to information that has already been released in response to this authorization. I must revoke this Authorization in writing to the CCCD and APA
- I may refuse to sign this Authorization:
  By doing so this will have no effect on the condition of my treatment or eligibility to receive service.

I have been informed and understand the information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law. Unless otherwise revoked, this authorization will not expire.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

Consent for Treatment:

I understand that the CCCD and APA will do all it can to provide necessary treatment and medical services within its scope of care and ability. I give consent to the CCCD and APA to render medical services, perform selective laboratory procedures and to work with other agencies to access services on my behalf.

In the event outside testing or referral is recommended:

1. I accept responsibility of any charges incurred.
2. I understand that Community Care Clinic has no financial obligation.
3. I am responsible for the making and / or keeping of appointments.

____ ____________________

Patient/Legal Guardian/Power of Attorney's Signature Date

Staff Initial:____________

COMMUNITY CARE CLINIC OF DARE

425 HEALTH CENTER DRIVE | P.O. BOX 1329

NAGS HEAD, NC 27959

CLINIC #: 252-261-3041 | FAX #: 252.255.6352

CHECKLIST

NAME:________________________________

DATE:________________PHONE#________________

[ ] ***PHOTO ID:*** NC DRIVERS LICENSE; NC ID; PASSPORT; COUNTRY CARD

[ ] ***PROOF OF RESIDENCY:*** UTILITY BILL,LEASE AGREEMENT;OR RESIDENCY DECLARATION.

OR

[ ] ***PROOF YOU ARE EMPLOYED IN DARE COUNTY:*** EMPLOYER STATEMENT INCLUDING EMPLOYER'S SIGNATURE AND PHONE # OR COPY OF CHECK STUB SHOWING EMPLOYER NAME AND ADDRESS

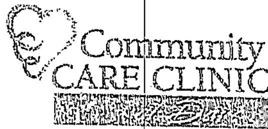
[ ] ***PROOF OF INCOME:*** PAYSTUBS-CAN ACCEPT YOUR LATEST PAYCHECK STUB(S) AS LONG AS IT COVERS A FULL 2 WEEKS PAY. (IF PAID WEEKLY PROVIDE 2 STUBS)

NOTE: **if you are married, provide the spouse's wage stubs also

[ ] IF YOU RECEIVE A MONTHLY BENEFIT SUCH AS UNEMPLOYMENT,SOCIAL SECURITY, PROVIDE THE BENEFIT LETTER FOR YOU/SPOUSE.

[ ] OTHER DOCUMENTS THAT MAY BE REQUIRED: ZERO INCOME STATEMENT;EMPLOYER STATEMENT;OR SELF EMPLOYMENT STATEMENT

THE CLINIC RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION IF DOCUMENTATION NOT SUFFICIENT.



425 Health Center Drive
[P.O. Box 1329], Nags Head, NC 27959

HIPAA NOTICE OF PRIVACY PRACTICES

Summary HIPAA Notice of Privacy Practices

The Community Care Clinic of Dare (CCCD) complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CCCD protects confidential health care information, known as "Protected Health Information" (PHI).Below is a summary of your privacy rights under HIPAA. CCCD legal duties and privacy practices regarding your PHI are also included in this Summary Notice.

Summary of Your Privacy Rights
CCCD may use and give your health information to:
*Treat you
*Operate/provide health care services

CCCD may use and give your health information for:
*Law enforcement requests
*Judicial and administrative proceedings related to legal actions
*Healthcare fraud and abuse detection or compliance with the law
*Use by another healthcare provider treating you
*Government health oversight activities
*Reports required by law related to births,deaths or diseases
*Reports required by law related to neglect and abuse,or domestic violence
*Notifying a party about exposure to a possible communicable disease
*Use by another healthcare provider for payment to that provider
*Military,national defense and security or other governmental functions
*Workers' compensation purposes and in compliance with related laws
*Averting a serious threat to public health and safety

You have the right to:
*Inspect or get a copy of your medical record
*Change information on your medical record if you think it is incorrect
*Get a list of persons whom CCCD shared your PHI
*Ask CCCD to limit the information it shares
*Ask for a copy of your privacy notice
*Write a letter of complaint to CCCD or the federal government

If you have any questions or if you wish to file a complaint, or exercise any rights listed in this Summary or the complete Notice, please contact Tami Montiel,Executive Director at (252)261-8041.

You are a valued patient at the Community Care Clinic of Dare and our goal is to continue to partner with you for a healthy tomorrow.

In order to continue providing quality primary care to the growing number of uninsured adults in our community, we are asking patients to contribute through per service or annual income-based fees.

Medication assistance, blood pressure checks, health education, lab follow-up visits, & many other services will be at no additional cost.

2021 Administrative Processing Fees Based on Household Income

Household Income As percent of Federal Poverty Limit (FPL) **(See FPL Table on Next Page)**	**Telehealth or Clinic Visit Fee** (pay with credit card online www.dareclinic.org & click on DONATE)	**Lab Work Visit Fee**	**Registration or Recertification Fee**	**ANNUAL FEE (if paid in full)** Based on 4 clinic visits/yr, 2 lab work visits/yr, & annual registration fee
☐ 0% - 100% FPL	$ 10	$ 5	$ 5	**$ 45**
☐ 101% - 150% FPL	$ 15	$ 10	$ 10	**$ 80**
☐ 151% - 200% FPL	$ 20	$ 15	$ 15	**$ 115**
☐ 201% - 250% FPL	$ 25	$ 20	$ 20	**$ 150**
☐ 251% - 300% FPL	$ 30	$ 25	$ 25	**$ 185**

Patient Name:	
Date of Birth:	
Phone Number:	
Annual Fee Paid in Full: ☐ YES ☐NO	☐CHECK ☐CASH ☐CREDIT CARD ☐SPONSOR: ________________
Household Income	$ __________ ________% FPL
Patient Signature:	______________________ Signature ________ Date

Persons in Household	Percent of Federal Poverty Limit				
	0-100%	101-150%	151-200%	201-250%	251-300%
1	$0 - $12,760	$12,887.60 - $19,140	$19,267.60 - $25,520	$25,647.60 - $31,900	$32,027.60 - $38,280
2	$0 - $17,240	$17,412.40 - $25,860	$26,032.40 - $34,480	$34,652.40 - $43,100	$43,272.40 - $51,720
3	$0 - $21,720	$21,937.20 - $32,580	$32,797.20 - $43,440	$43,657.20 - $54,300	$54,517.20 - $65,160
4	$0 - $26,200	$26,462 - $39,300	$39,562 - $52,400	$52,662 - $65,500	$65,762 - $78,600
5	$0 - $30,680	$30,986.80 - $46,020	$46,326.80 - $61,360	$61,666.80 - $76,700	$77,006.80 - $92,040
6	$0 - $35,160	$35,511.60 - $52,740	$53,091.60 - $70,320	$70,671.60 - $87,900	$88,251.60 - $105,480
7	$0 - $39,640	$40,036.40 - $59,460	$59,856.40 - $79,280	$79,676.40 - $99,100	$99,496.40 - $118,920
8	$0 - $44,120	$44,561.20 - $66,180	$66,621.20 - $88,240	$88,681.20 - $110,300	$110,741.20 - $132,360