FLORIDA ATLANTIC UNIVERSITY
Christine E. Lynn College of Nursing

NCHA
NORTHWEST COMMUNITY HEALTH ALLIANCE, INC.

Community Health Packet

Dear Patient: We are a non-profit clinic that provides low-cost health care on a sliding scale. Visit costs for patients are determined by a sliding fee scale that is calculated based on income and household size. This practice serves all patients regardless of inability to pay. Due to new federal reporting regulations; the following information is now required for each patient. Please note that all information is confidential. We appreciate your cooperation with these new reporting requirements and will need to collect this information on an annual basis.

Today's Date: _____

Patient Information: Last Name: _____First Name: _____ MI: _____

Date of Birth: _____ SSN: _____ Sex Assigned at Birth: ☐ Male ☐ Female

Address: _____ City: _____ Zip Code: _____

Phone Number: _____ Email address: _____

Pharmacy Name /Pharmacy Address: _____

Allergies: ☐ No ☐ Yes, explain _____

Living Arrangements:

Transportation:

○ Shelter (safe havens, temporary overnight housing, armories) ○ Transitional (center, community, Home) ○ Other (hotel, motel/public housing)	○ Doubling Up (living with other people for a temporary period and move often) ○ Street (sidewalk, car, park, doorway, public or abandon building)	☐ Permanent Resident (own, rent, apartment/room/house) ☐ Unhoused	○ Car ○ Bus-line ○ Walk/bike ○ Transport van

Structured information:

Do you have limited access to food? ☐ No ☐ Yes If yes, please explain: If yes, please explain:
_____

Occupation: _____ ☐ full-time ☐ part-time ☐ student ☐ seasonal worker ☐ migrant worker

Country of origin: _____

Limited English: ☐ No ☐ Yes Do you need a translator? ☐ No ☐ Yes ☐ N/A

How did you hear about FAU clinics? ☐ outreach ☐ internet ☐ insurance ☐ family/friend ☐ other

Insurance information: (Choose one)

- Self-pay
- Medicaid (Plan name and member number) _____
- Private or Medicare (Plan name and member number) _____
- Employment Status: _____

Ethnic Origin: (Please check one) Hispanic: ☐ Yes ☐ No

Race: (please check all that apply)

☐ Caucasian ☐ Asian ☐ Pacific islander ☐ Native Hawaiian
☐ Black or African American ☐ American Indian/Alaskan Native ☐ Choose Not to-Disclose

Gender Identity:

☐ Male ☐ Transgender Male/Female-to-Male ☐ Choose Not to-Disclose
☐ Female ☐ Transgender Female/Male-to-Female ☐ Other

Sexual Orientation:

☐ Straight ☐ Bisexual ☐ Don't know
☐ Lesbian or Gay ☐ Other: ☐ Choose Not to-Disclose

Pronouns:

☐ he/him/his/his/himself
☐ she/her/her/hers/herself
☐ they/them/their/theirs/themselves

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner

Emergency Contact:

Last Name: _____ First Name: _____

Relation to Patient: _____ Phone Number: _____

In case of an emergency, the FAU/NCHA Community Clinic may provide your medical records to a hospital or other medical institution if you are unable to make medical decisions on your own behalf.

If you DO NOT want your medical records sent on your behalf in an emergency, please check this box:

☐ I do NOT want my medical records released on my behalf in an emergency.

CONSENT FOR TREATMENT

Name: _____ DOB: _____

I, _____authorize and voluntarily consent to the FAU Christine E. Lynn College of Nursing Community Health Center to provide preventive, diagnostic, and therapeutic procedures and treatment. These services may include, but are not limited to, physical examinations, laboratory tests, immunizations, and other medical procedures deemed necessary or advisable by the attending Health Care Provider, their assistants, or designees.

This consent applies to:

- ☐ **Myself**, if I am the patient and 18 years of age or older, **or**
- ☐ **The minor or dependent individual named above**, for whom I am the parent, legal guardian, or authorized representative.

I understand that no guarantees have been made regarding the results of the treatment or examinations. I have read and understand this consent form and accept its contents.

_____	_____	_____
Signature:	Relationship to Patient:	Date:

1650 Osceola Dr, West Palm Beach Fl, 3340
720 8th St, West Palm Beach Fl, 33401
561.803.8880 | 561.557.2052

How would you identify your current health status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

When was your last physical exam? _____

In the past 12 months, have you been hospitalized or to the Emergency Room?

No ☐ Yes ☐ , if yes, explain where and why: _____

Do you take any perscription, non-perscription drugs, herbs, or supplements routinely?

No ☐ Yes ☐ , if yes, please list your medications:

Medication Name/Dosage:	How many times per day:	When do you take them:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History: Check all that apply to you

Hypertension: ☐ Stroke: ☐ Heart Disease: ☐ Diabetes: ☐

Thyroid: ☐ Lung Disease: ☐ Seizures: ☐ Stomach Disorders: ☐

Cancer: ☐ Other (explain): _____

Have you ever had surgery? No ☐ Yes ☐ ,if yes, please explain: _____
Have you ever had a Colonoscopy? No ☐ Yes ☐ (year):___
Dental Visit? No ☐ Yes ☐ (year):___
Have you ever been to the eyedoc? No ☐ Yes ☐ Corrective lenses? No ☐ Yes ☐

Social History

Smoke cigarettes or vape? No ☐ Yes ☐ If yes, how many packs of cigarettes per day __
Vape: How many times a day do you vape?___what do you vape (nicotine,THC, both or other)? _____
Do you consume caffeine regularly (e.g., coffee, tea, energy drinks, soda)? ☐ No ☐ Yes — If yes, how many servings per day? _

Do you drink alcohol? (e.g., wine, beer, liquor) ☐ No ☐ Yes — If yes, how often and how much? _____

Women only: Last period date: _____ Mammogram Date: _____ PAP SMEAR Date: _____

Mental Health: Check all that apply to you:

- ☐ Anxiety
- ☐ Depression
- ☐ Extreme worry
- ☐ Trouble sleeping
- ☐ Trouble thinking or concentrating

Sucidial Risk Assessment:

Have you ever had feelings or thoughts that you did not want to live? ☐ No ☐ Yes, if yes, please explain

_____

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? ☐ No ☐ Yes, if yes, please explain _____

Is there anything that would stop you from killing yourself? ☐ No ☐ Yes, if yes, please explain _____

Do you feel hopeless and/or worthless? ☐ No ☐ Yes, if yes, please explain _____

Have you ever tried to kill or harm yourself before? ☐ No ☐ Yes, if yes, please explain _____

Do you have access to guns? ☐ No ☐ Yes, if yes, please explain _____

Check if you have ever tried the following:

- ☐ Methamphetamine
- ☐ Cocaine
- ☐ Stimulants (pills)
- ☐ Heroin
- ☐ LSD or Hallucinogens
- ☐ Marijuana
- ☐ Pain killers (not as prescribed) Methadone
- ☐ Tranquilizer/sleeping pills
- ☐ Alcohol
- ☐ Ecstasy
- ☐ Other, explain: _____

Spiritual Life: Do you belong to a particular religion or spiritual group? ☐ No ☐ Yes (Explain) _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Florida Atlantic University Notice of Privacy Practices and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

Signature of Patient (or Authorized Personal Representative) | Patient's Student ID/Z# | Date

Print Name of Patient (or Authorized Personal Representative | Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate)

NOTICE OF LIMITED LIABILITY PURSUANT TO SECTION 1012.965, FLORIDA STATUTES

I, on behalf of myself, my child, and/or my ward, acknowledge that I have been notified that:

I, my child, and/or my ward, will receive medical care and treatment provided by employees and/or agents of the Florida Atlantic University Board of Trustees (hereafter referred to as "FAU") at this facility.

The FAU employees and/or agents providing this medical care and treatment may include, but are not limited to: physicians, residents, fellows, healthcare students, physician assistants, advanced registered nurse practitioners, perfusionists, nurses, pharmacists, and technicians, who will at all times be under the exclusive supervision and control of FAU. I, on behalf of myself, my child, and/or my ward, understand that the employees of FAU are not employees or agents of any entity other than FAU.

Additionally, I, on behalf of myself, my child, and/or my ward, understand that liability, if any, which may arise from the care rendered by FAU health care providers is limited as provided by law. The law provides that "Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000." (Section 768.28(5), Florida Statutes)

Signature of Patient (or Authorized Personal Representative) | Date

Print Name of Patient (or Authorized Personal Representative) | Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate)

Printed Name of Witness | Date

AGREEMENT TO MEDIATE

In accepting care at this facility where FAU employees and/or agents provide medical care and treatment, I agree that before I file any lawsuit against the FAU Board of Trustees for medical care and treatment rendered by its health care providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party who has been certified to be a mediator tries to help settle claims. FAU will pay the cost of the mediator. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

Signature of Patient (or Authorized Personal Representative) | Date

Print Name of Patient (or Authorized Personal Representative) | Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate)

Printed Name of Witness | Date _____