CROSSINGS
COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

Patient Name:	MRN#:

We are excited for the opportunity to help meet your healthcare needs.
To accept and begin review of your application, this packet must include:

☐	**VALID PHOTO ID**
	May include a copy, or present ID to clinic front desk staff who will be happy to copy for you.
☐	**RECENT UTILITY BILL**
	For proof of residence in our service area, if utility bill not in your name, provide an alternate bill or piece of mail addressed to you at your current physical address.
☐	**PROOF OF HOUSEHOLD INCOME**
	Most recent year's TAX RETURN for ALL MEMBERS of your household who earn financially. Any AWARD LETTERS OR CARDS that support your current state of financial need. Examples include: social security, unemployment, housing or food assistance benefits (SNAP card), child or spousal support, workers' comp, disability, etc. *Please note: In order to provide our patients with free or low-cost referrals to specialists, lab, and imaging services which are required for primary care, we partner with outside organizations such as the Health Alliance for the Uninsured (HAU). Because these agencies REQUIRE us to provide patients' proof of income, we must have this information up to date and on file for all current patients. If you do not have the specific forms listed above, please call the clinic and request to speak with someone regarding proof of income requirements for potential new patients. **Note:** If you **DO NOT** have last year's tax return, you will need to **provide updated financial information at EVERY appointment as requested.**
☐	**COMPLETED APPLICATION PACKET PAPERWORK**
	Registration form, Health History, Patient Rights and Responsibilities, Information/Privacy Acknowledgement, Consent for Services

If you need help completing your packet, or have questions about the application process, please contact the clinic directly at (405)749-0800.

Packet accepted by:	Date:
Financial Document review by:	Date:
Nurse Review by:	Date:
☐ APPROVED/**Appt Date & Time:**	☐ DENIED/ Reason:

Date:	Note:

______ **Patient Initials**

Crossings Clinic is unable to treat emergency conditions or Workman's Comp injuries and cannot establish social security disability or assist patients with court cases related to their medical condition. The clinic does not have the resources to determine a patient's ability or inability to perform any type of work.

CROSSINGS
COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

Dear Potential New Patient,

We are so blessed that you're considering Crossings Community Clinic to serve your medical needs. We look forward to addressing your health concerns, and in order to qualify as a patient you will need to meet the following guidelines:

1. Have no medical or dental insurance
2. Be between the ages of 18 and 64 (Medical Only)
3. Live in one of the following zip codes: 73114, 73120, 73132, 73162
4. Have proof of income and living at or below 200% of the Federal Poverty Guidelines

Note: Spanish speaking only patients are responsible for bringing an interpreter who is 18 years or older.

If you believe you meet these requirements, please complete our new patient application and provide us with a **utility bill, recent tax return and a photo ID**. We will then confirm your eligibility and if approved, contact you to schedule a new patient appointment.

Our goal is to help you during this time when you have no access to healthcare and no means to pay for private care. We hope to partner with you in a holistic approach to your overall wellness, to include your physical, emotional, and spiritual health. As a patient of Crossings Community Clinic, you will be provided limited medical, dental, and vision care at no charge, limited medication allocation and/or written prescriptions to be filled by your local pharmacy. We encourage our patients to participate in recovery, nutrition, diabetic education, and fitness classes for your benefit at no cost. As your financial situation improves, we will offer services to assist you in the process of obtaining private insurance or reduced fee medical care at clinics with a full range of services.

We believe God directed you our way to serve you the best way we can. If we are unable to serve your medical needs at our clinic, we will provide you a resource list of other low cost or charitable clinics in the area.

Most of all, please know that you are loved by God and He truly cares for you.

Blessings,

Crossings Community Clinic

"…Love your neighbor as yourself."

Mark 12:30-31

CROSSINGS
COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

PATIENT INFORMATION

Full Legal Name: (last, first, middle) | Date of Birth:

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married ☐ Partnered

Age:

Social Security Number: - -

What is your race? (Check all that apply.)
☐ Asian ☐ Native Hawaiian
☐ Other Pacific Islander ☐ Black/African American
☐ American Indian/Alaska Native ☐ White ☐ Other

What is your ethnicity?
☐ Hispanic/Latino
☐ Not Hispanic/Latino

US Citizen? (clinic purposes only)
☐ Yes ☐ No

Primary Language Spoken:
☐ English ☐ Spanish ☐ Other________________________

Current Home Address: (Include city, state, zip)

Homeless? Circle: YES / NO

Home Phone Number: ( ) -

Cell Phone Number: ( ) -

Email Address

EMERGENCY CONTACTS

Name:
Relationship:
Phone:
OK to share medical information? YES / NO

Name:
Relationship:
Phone:
OK to share medical information? YES / NO

INSURANCE COVERAGE AND ELIBILITY

ARE YOU ELEGIBLE FOR OR COVERED BY:	YES	NO	APPLIED	PENDING	DENIED
MEDICARE (Age 65+)					
MEDICAID/SOONERCARE (Low income state provided)					
INDIAN HEALTH SERVICES (CDIB card)					
PRIVATE INSURANCE(marketplace or employer-offered)					
VETERANS HEALTH BENEFITS					

HOUSEHOLD FINANCIAL INFORMATION

How many adults (18+) live in your home?

How many children (under 18)?

How many people in the home have an income of any kind?
(including unemployment, disability, SSI, retirement income)

Total amount that YOU earn for the household? $________________ ☐ weekly ☐ biweekly ☐ monthly ☐ yearly

COMBINED income earned by ALL members of the household?
$_______________ ☐ weekly ☐ biweekly y ☐ monthly ☐ yearly

DID YOU FILE TAXES FOR LAST YEAR?
☐ YES ☐ NO ☐ UNSURE

ADDITIONAL INFORMATION

Have you been seen as a patient of Crossings Community Clinic before? ☐ Yes ☐ No

Primary Health Concern(s):

VISION care needs? ☐ YES ☐ NO

DENTAL care needs? ☐ YES ☐ NO

How long have you been without medical insurance?

Last doctor who cared for you regularly?

Preferred Pharmacy:

CROSSINGS
COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

HEALTH HISTORY – PATIENT ESTABLISHING CARE:

MEDICATIONS (including herbals, birth control, and over-the-counter meds) ☐ **None**

	Name	Dose	Taking	Not Taking	Need Refills
1			☐	☐	☐
2			☐	☐	☐
3			☐	☐	☐
4			☐	☐	☐
5			☐	☐	☐
6			☐	☐	☐
7			☐	☐	☐
8			☐	☐	☐
9			☐	☐	☐
10			☐	☐	☐
11			☐	☐	☐
12			☐	☐	☐
13			☐	☐	☐
14			☐	☐	☐
15			☐	☐	☐

CURRENT AND PAST MEDICAL PROBLEMS *(check all that apply)* ☐ **None**

☐ Anxiety/Depression
☐ Thoughts of harming yourself or others
☐ Asthma
☐ Currently Pregnant
☐ Currently Nursing
☐ Diabetes
☐ High Blood Pressure
☐ Allergies or Hay Fever
☐ Artificial joint or bone replacement
☐ Blood clots, DVT, Pulmonary Embolism
☐ Bone, muscle or joint disorder
☐ Cancer or Leukemia
☐ Endocarditis
☐ Emphysema, COPD, Chronic Bronchitis
☐ Enlarged Heart or CHF
☐ Epilepsy, Seizures, Convulsions
☐ Headaches or Migraines
☐ Heart Attack or Chest Pain
☐ Heart Valve Defect or Surgery
☐ Heart Bypass, Angioplasty, Stents
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis, Jaundice or Liver Disease
☐ HIV positive or AIDS
☐ Heart Pacemaker or Defibrillator
☐ Kidney Dialysis
☐ Schizophrenia / Bipolar
☐ Stroke
☐ Sickle Cell Disease or Trait
☐ Transplanted Organ

Other: ____

____

ALLERGIES ☐ **None**

Food allergies: ______________________________
Medication allergies: ______________________________
Are you allergic to Iodine or shellfish? ☐ YES ☐ NO
Are you allergic to Latex or rubber? ☐ YES ☐ NO

SURGERIES ☐ **None**

Month / Year	**Type of Surgery**

HOSPITALIZATIONS / ER VISITS ☐ **None**

Month / Year	**Reason for hospital stay / ER Visit**

CROSSINGS COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

FAMILY HISTORY (check all that apply)									☐ **None / Unknown**
Family Member	Still Living?	Diabetes	High Blood Pressure	Heart Disease	Cancer	Asthma	Birth Defect	Mental Illness	Substance Abuse
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother's Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother's Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father's Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father's Father	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other: ____

____

TOBACCO USE / SMOKING					
Are you currently a smoker?	☐ Yes	☐ No	Do you use other forms of tobacco? *(check all that apply)*	☐ pipe ☐ cigars ☐ e-cigarettes	☐ snuff ☐ chew ☐ vape
	☐ Former Smoker				
Do you smoke every day?	☐ Yes	☐ No	How many years have you smoked?		
How many packs of cigarettes per day?	☐ less than half a pack ☐ 1 pack ☐ more than 1 pack		How long since you <u>last</u> smoked?	☐ < 1 month ☐ 3-6 months ☐ 7-12 months	☐ 1-5 years ☐ 6-10 years ☐ > 10 years
Are you:	☐ Ready to quit	☐ Thinking about quitting	☐ Not ready to quit		

ALCOHOL USE				
Did you have a drink containing alcohol in the past year?			☐ Yes	☐ No
If yes, how often did you drink?	☐ monthly or less	☐ 2-4 times per month	☐ 2-3 times per week	☐ 4+ times per week
How many drinks did you have on a typical day when you were drinking in the past year?				
How often do you have 6 or more drinks on one occasion?				

SUBSTANCE USE				
Have you used any non-medical drugs in the past 12 months?			☐ Yes	☐ No
If yes, which drug(s) (including marijuana):		Are you still using?	☐ Yes	☐ No
How many months ago did you last use?	☐ <6 months	☐ 6-12 months	☐ 12-24 months	☐ 24+ months

SEXUAL HISTORY					
Are you sexually active?	☐ Yes, within the last month ☐ Yes, in the past ☐ Never been sexually active		Do you have any history of sexually transmitted infections?	☐ Yes	☐ No
Do you have sex with?	☐ Men ☐ Women	☐ Both ☐ Neither	If yes, which infections?	☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ HIV	☐ Herpes ☐ Syphilis ☐ Trichomonas ☐ __________
Do you use birth control/protection?					

CROSSINGS COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

WOMENS HEALTH HISTORY	MENS HEALTH HISTORY
Do you have periods? ☐ YES ☐ NO ☐ IRREGULAR	History of testicular trauma or surgery: ☐ YES ☐ NO
Last well woman exam (month/year): Last mammogram (month/year): Any breast changes/lumps?:	History of men's health concerns: (STD/STI / testicular pain or swelling/ penile pain or discharge / visible sores/ sexual difficulties) ☐ YES ☐ NO
History of women's health concerns: (History of STD or pelvic infection/ infertility/ fibroids or cysts/ abnormal pap/ HPV/) ☐ YES ☐ NO Explain:_	Year of last prostate/rectal exam:
Obstetric History: Total number of pregnancies in your life: Total number of early losses (including early miscarriage or abortion): Total number of full-term births: Total number of premature births: Number of living children:	Prostate Concerns: Any trouble urinating or emptying bladder? ☐YES ☐NO Waking at night to urinate? ☐ YES ☐ NO Blood in urine? ☐ YES ☐ NO Kidney/urine/prostate infection? ☐ YES ☐ NO Testicular pain or swelling with straining/lifting/ or coughing? ☐ YES ☐ NO

OTHER			
As a child, did you complete the recommended vaccination series?	☐ Yes	☐ No	☐ Unsure
Have you ever had any of the following illnesses? ☐ YES *(check all that apply)* ☐ NO ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Shingles ☐ Polio ☐ Rheumatic Fever			
Have you had any of the following vaccines as an adult? ☐ YES *(check all that apply & write year)* ☐ NO ☐ Tetanus/Tdap/dTap __________ ☐ Flu vaccine __________ ☐ Pneumonia vaccine __________ ☐ Other __________			
Do you have concerns about your diet? ☐ YES ☐ NO Explain:			
Have you ever had a colonoscopy ☐ YES ☐ NO If yes, year:			

DEMOGRAPHIC INFORMATION	
Marital Status:	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married ☐ Partnered
Spouse Name:	Number of Children:
What is the highest level of school you have completed?	☐ Elementary School ☐ High School ☐ College ☐ Graduate School
What is the highest degree you earned?	☐ High School Diploma ☐ GED ☐ Vocational certification ☐ Associate's degree (junior college) ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate

CROSSINGS
COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

Health starts where we work, play, learn, eat, and sleep. Problems in any of these areas can affect your health. We may be able to provide assistance, so we hope you will answer the following questions. You do not have to answer any questions you do not want to. Anything you write will be kept confidential in your medical record.

PLEASE CHECK THE BOX FOR YOUR ANSWERS.

Which best describes your current occupation?

- ☐ Homemaker, not working outside the home
- ☐ Employed (or self-employed) full time
- ☐ Employed (or self-employed) part time
- ☐ Employed, but on leave for health reasons
- ☐ Employed but temporarily away from my job (other than health reasons)
- ☐ Unemployed or laid off 6 months or less
- ☐ Unemployed for more than 1 year

What is your housing situation today?

- ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, or in a park)
- ☐ I have housing today, but I am worried about losing housing in the future
- ☐ I have housing

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- ☐ Yes
- ☐ No
- ☐ Already shut off

Think about the place you live. Do you have problems with any of the following?
(Check all that apply)

- ☐ Bug infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Inadequate heat
- ☐ Oven or stove not working
- ☐ No or not working smoke detectors
- ☐ Water leaks
- ☐ None of the above

How confident are you filling out forms by yourself?

- ☐ Not at all
- ☐ Somewhat
- ☐ Extremely

How confident are you that you can control and manage most of your health problems? (Select a number from 1 to 10.
1 = not at all confident 10 = very confident)

1 2 3 4 5 6 7 8 9 10

Not at all Very Confident

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- ☐ Not hard at all
- ☐ Not very hard
- ☐ Somewhat hard
- ☐ Hard
- ☐ Very hard

Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ☐ Never true
- ☐ Sometimes true
- ☐ Often true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- ☐ Never true
- ☐ Sometimes true
- ☐ Often true

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

- ☐ Yes
- ☐ No

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?

- ☐ Yes
- ☐ No

Do you feel stress–tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time–these days?

- ☐ Not at all
- ☐ Only a little
- ☐ To some extent
- ☐ Rather much
- ☐ Very much

CROSSINGS
COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

- ☐ Never
- ☐ Once a week
- ☐ Twice a week
- ☐ Three times a week
- ☐ More than three times

How often do you get together with friends or relatives?

- ☐ Never
- ☐ Once a week
- ☐ Twice a week
- ☐ Three times a week
- ☐ More than three times

How often do you attend church or religious services?

- ☐ Never
- ☐ 1 to 4 times per year
- ☐ More than 4 times per year

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?

- ☐ Yes
- ☐ No

Within the last year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?

- ☐ Yes
- ☐ No

Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?

- ☐ Yes
- ☐ No

Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

- ☐ Yes
- ☐ No

CROSSINGS
COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

PATIENT RIGHTS AND RESPONSIBILITIES

Name: *(Last, First, M.I.)*	**DOB:**

At Crossings Community Clinic, we believe in team-based health care. This means that we, as health care providers have an active role, and you, as a patient have an active role.

Crossings Community Clinic is responsible for:

- Providing evidence-based primary care services.
- Providing considerate and respectful care.
- Explaining all procedures and test results at patient appointments.
- Doing our best to respond to all calls and messages within 24 hours during weekdays.
- Keeping all medical information private.

You, as a patient, are responsible for:

*****Please initial each line to acknowledge that you have read your responsibilities as a patient at Crossings Community Clinic and agree to comply.**

- ______ Being on time for appointments. If you need to cancel or reschedule, you must call us at (405) 749-0800 at least 24 hours prior to the appointment time. Leaving a voicemail is acceptable. If you miss three (3) appointments in one year without calling, Crossings Community Clinic may discontinue care.
- ______ Obtaining any lab testing or imaging that is ordered by your physician prior to your next appointment.
- ______ Informing Crossings Community Clinic within 30 days of any changes in your insurance status, income, or contact information. Failure to do so may result in delayed treatment.
- ______ Timely providing updated household financial information each year.
- ______ Being an active partner in managing your health.
- ______ ***Spanish speaking only patients are responsible for bringing an interpreter who is 18 years or older to all appointments.***

Patient information:

- **Medications:** Crossings Community Clinic does not prescribe or dispense any narcotics or controlled substances. Please notify us 10 days before you run out of a medication. We will not be able to fill walk in medication requests.
- **Courtesy:** Crossings Community Clinic will not tolerate inappropriate/abusive language, behavior and/or treatment directed toward providers/staff/volunteers by patients and/or their representatives. The clinic reserves the right to refuse treatment.
- **Limitations:** Crossings Community Clinic is limited in the services which can be provided to patients and cannot guarantee access to specialty referrals and imaging. **The clinic is unable to treat emergency conditions or Workman's Comp injuries and cannot establish social security disability or assist patients with court cases related to their medical condition.** The clinic does not have the resources to determine a patient's ability or inability to perform any type of work.

I HAVE READ AND UNDERSTAND THIS PATIENT RIGHTS AND RESPONSIBILITIES DOCUMENT AND AGREE TO COMPLY WITH ALL OF ITS TERMS AND CONDITIONS.

Patient/Guardian Signature: ______________________________ Date: ________________

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

PATIENT INFORMATION AUTHORIZATION AND PRIVACY ACKNOWLEDGMENT

Name: *(Last, First, M.I.)*	**DOB:**

AUTHORIZATION TO CONVEY PERSONAL HEALTH INFORMATION BY MESSAGE

I authorize Crossings Community Clinic staff, providers, and volunteers to leave messages for me at phone numbers I have provided to them as personal contact information. I understand that these messages could include Protected Health Information (PHI) pertaining to my appointment dates/times, care, and treatment and may come in the form of voicemail or text message.

I AUTHORIZE CROSSINGS COMMUNITY CLINIC TO LEAVE MESSAGES CONTAINING PROTECTED HEALTH INFORMATION:
Select all that apply: ☐ By Voicemail ☐ Via Text Message ☐ With Family/Friends ☐ No Messages Please

AUTHORIZATION TO SHARE PERSONAL HEALTH INFORMATION

I give permission for Crossings Community Clinic to provide my Protected Health Information to the following people:

NAME	RELATIONSHIP	PHONE NUMBER

I acknowledge and understand that this authorization will be kept as part of my medical record and will remain in effect until revoked by me in writing. It is my responsibility to inform Crossings Community Clinic should I wish to change any of my contact information.

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the opportunity to review the Crossings Community Clinic's Notice of Privacy Practices and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

_______________________________ _______________

Patient/Guardian signature *Date*

CROSSINGS
COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

CONSENT FOR SERVICES

Name: *(Last, First, M.I.)*	**DOB:**

**PLEASE READ THIS FORM CAREFULLY,
AS IT CONTAINS IMPORTANT INFORMATION PERTAINING TO YOUR CARE.**

My signature below signifies that I understand the following:

- Medical services offered through Crossings Community Clinic may be administered by a variety of licensed medical professionals.
- Non-medical services may be provided by a variety of non-licensed professionals, counselors or other clinicians, which may include students or interns.
- To ensure continuity of care, it may be necessary for Crossings Community Clinic's care providers (physicians, counselors, dentists, etc.) to share information about you with other providers involved in your care.

VOLUNTEER MEDICAL PROFESSIONAL SERVICES IMMUNITY ACT
STATEMENT OF DISCLOSURE AND ACKNOWLEDGEMENT

Oklahoma Law provides that certain medical professionals are **immune from liability in a civil action** based on the acts or omissions of those professionals in providing volunteer medical professional services. The law covers physicians, physician's assistants, registered nurses, advanced nurse practitioners, vocational nurses, pharmacists, podiatrists, dentists, dental hygienists or assistants, medical assistants, occupational or physical therapists, psychologists, and optometrists if:

1. The volunteer medical services were provided at a free clinic where neither the professional(s) nor the clinic receives any kind of compensation for any treatment provided at the clinic;
2. The professional(s) were engaged in active practice or if retired, were still eligible to provide medical professional services within the state.
3. The professional(s) were acting in good faith and, if licensed, the services provided were within the scope of the licenses of the professional(s);
4. The professional(s) committed the act or omission in the course of providing professional services:
5. The damage or injury was not caused by gross negligence or willful and wanton misconduct by the professional(s).

I understand that based upon provisions 1-5 above from the Volunteer Professional Services Immunity Act, that I am giving up my right to recover for injuries or damages in a lawsuit against any volunteer professional(s), health practitioner, or the Crossings Community Clinic in exchange for receiving free professional medical services.

I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of any procedures and/or treatments performed. I acknowledge that even though my Provider will seek to advise me of known risks involved with any treatments and/or procedures performed, additional unforeseeable and/or unpreventable situations could arise in the course of my care, which might result in injury.

I have read and understand the above consent form in its entirety. Any questions have been answered to my satisfaction in a language that I understand. Understanding the above, I hereby give my consent to receive services from Crossings Community Clinic. My consent is valid until I withdraw it.

Patient/Guardian signature: ______________________________ Date: _____________

CROSSINGS COMMUNITY CLINIC

10255 NORTH PENNSYLVANIA AVE
OKLAHOMA CITY, OK 73120
405.749.0800

PATIENT RIGHTS AND RESPONSIBILITIES

At Crossings Community Clinic, we believe in team-based health care. This means that we, as health care providers have an active role, and you, as a patient have an active role.

Crossings Community Clinic is responsible for:

- Providing evidence-based primary care services.
- Providing considerate and respectful care.
- Explaining all procedures and test results at patient appointments.
- Doing our best to respond to all calls and messages within 24 hours during weekdays.
- Keeping all medical information private.

You, as a patient, are responsible for:

*****Please initial each line to acknowledge that you have read your responsibilities as a patient at Crossings Community Clinic and agree to comply.**

PATIENT COPY

__ Being on time for appointments. If you need to cancel or reschedule, you must call us at (405) 749-0800 at least 24 hours prior to the appointment time. Leaving a voicemail is acceptable. If you miss three (3) appointments in one year without calling, Crossings Community Clinic may discontinue care.

__ Obtaining any lab testing or imaging that is ordered by your physician prior to your next appointment.

__ Informing Crossings Community Clinic within 30 days of any changes in your insurance status, income, or contact information. Failure to do so may result in delayed treatment.

__ Timely providing updated household financial information each year.

__ Being an active partner in managing your health.

__ ***Spanish speaking only patients are responsible for bringing an interpreter who is 18 years or older to all appointments.***

Patient information:

- **Medications:** Crossings Community Clinic does not prescribe or dispense any narcotics or controlled substances. Please notify us 10 days before you run out of a medication. We will not be able to fill walk in medication requests.
- **Courtesy:** Crossings Community Clinic will not tolerate inappropriate/abusive language, behavior and/or treatment directed toward providers/staff/volunteers by patients and/or their representatives. The clinic reserves the right to refuse treatment.
- **Limitations:** Crossings Community Clinic is limited in the services which can be provided to patients and cannot guarantee access to specialty referrals and imaging. **The clinic is unable to treat emergency conditions or Workman's Comp injuries and cannot establish social security disability or assist patients with court cases related to their medical condition.** The clinic does not have the resources to determine a patient's ability or inability to perform any type of work.

I HAVE READ AND UNDERSTAND THIS PATIENT RIGHTS AND RESPONSIBILITIES DOCUMENT AND AGREE TO COMPLY WITH ALL OF ITS TERMS AND CONDITIONS.

PATIENT COPY