Patient Name:	**MRN#**

At Amor Telehealth Center (ATC), we are excited for the opportunity to take care of your healthcare needs. To qualify as a patient at ATC Clinic, you will need to meet the following guidelines:

1. **Have a valid photo ID**. May include a copy, or present ID to the clinic front desk and the staff will be happy to copy for you.
2. **Have no medical insurance.**
3. **Have proof of household financial and income of living at or below 300% of the Federal Poverty Guidelines.**
4. **Completed application packet paperwork**. Application Packet includes Registration form, Health history, Patient rights and Responsibilities, Information Acknowledgement, and Consent for Services.

   If you need help completing your packet, or have questions about the application process, please contact us directly at 405-528-6327 Ext 304.

   Please if you believe you meet the listed above requirements, fill the application, provide us with a valid photo ID and we will contact you to schedule an appointment with our provider.

Packet accepted by:	
Financial Document review by:	
Nurse Review by:	
Approved Appt Date & Time:	Denied: Reason:
Date:	Note:

PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____First Name: _____MI: _____Social Security #: _____

Address: _____City: _____State: _____Zip: _____

Email: _____Occupation: _____

Date of Birth: _____ Sex: M F Marital Status: Married Single Divorced

Race: American Indian or Alaska Asian Black or African American Native White Unknown/Declined to answer

Ethnicity: Hispanic Not Hispanic or Latino Declined to answer

Home phone_____ Cell Phone _____ Work Phone _____

Best daytime number to reach you: Is it ok to leave a message at any of the numbers? Yes No

If no please designate which ones, if any:

Primary Care Physician's Name (if applicable): _____How did you hear about us? _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

Insurance Coverage and Eligibility

Are you eligible for or covered by:	Yes	No	Applied	Pending	Denied
Medicare (Ages 65+)					
Medicaid/Sooner Care (State Provided for low-income)					
Indian Health Services (CDIB Card)					
Private Insurance					
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 ❖ monthly ❖ yearly

Chief Complaint/Problem list:

……

……

……

……

……

……

……

Health History:

Whole System	**Circle**
Heart: Heart attack, surgery, CHF, Pacemaker	Y/N
Digestive: Ulcers, constipation, gallbladder	Y/N
Psychological: depression, anxiety, OCD, ADD	Y/N
Breathing: Asthma, seasonal allergies	Y/N
Risk factors such as High blood pressure, high cholesterol, obesity, addiction	Y/N
Urinary: Kidney stones, frequent UTI, prostate issue, uterus or ovary issue	Y/N
History of Cancer, TB, Hepatitis, HIV/AIDS, Blood clots	Y/N
Endocrine: Diabetes, pre-diabetes, pancreatitis	Y/N

Please indicate whether you have a Family History of any of the following and list family members who are affected with these conditions:

Diabetes	Y/N	Relationship:
Heart Disease	Y/N	Relationship:
Stroke	Y/N	Relationship
Asthma	Y/N	Relationship
Cancer	Y/N	Relationship

Please list all medications you currently take; None _____ _____
Preferred Pharmacy:
Please list any drug; food or other allergies you have; None. _____ _____

Do you smoke?

No If you are an ex-smoker when did you stop? …….

Yes How many per day? …….

Do you consume alcohol?
No

Yes How many standard drinks per day……. Week…….
Occasionally

When did you last have these immunizations?

Influenza Date;

Pneumonia Date;
Tetanus Date;

Women's Health

Is there any possibility that you could be pregnant? (Circle) YES NO NOT SURE

Are you sexually active? YES / NO

Do you use or need birth control? YES / NO

Total number of pregnancies in your life?

When was your last Pap Smear?

Date if known……

Within last 12 months; Within last 2 years; More than 2 years ago; More than 4 years ago;

Never

Not required

Men's Health

Are you sexually active? YES / NO

When was your last Prostate check?

Date if known……

Within last 12 months; Within last 2 years; More than 2 years ago; More than 4 years ago;

Never

Blood in urine? Y / N

Office use only
Date entered _____ / _____ / _____
Name

We Care for your Health.

Patient Information Authorization and Privacy Acknowledgement

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

Amor Telehealth center, Inc collect information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may accurately assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our healthcare care practice.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this care practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- To contact you or your family for the purposes of Recalls & Reminders.

Patient information shall not be released to a third party without the expressed consent of the patient.
I have read the information above and understand the reasons why my information is collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above.

Signed _____ Date _____

Name: _____

Authorization to convey personal health information by message.

I authorize Amor Telehealth Center 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 follow up scheduling and appointment dates/times, care, and treatment and may come in the form of text or voice message.

I authorize Amor Telehealth Center Clinic to leave messages containing Protected Health Information:

Select all that apply: 1) By Voicemail 2) Via Text Message 3) With Family/Friends

4) No Messages

Authorization to share Personal Health Information

I give permission for Amor Telehealth Center Clinic to provide my protected Health Information to the following people:

Name	Relationship	Phone#

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.

Patient acknowledgement of notice of privacy practices:

I……..hereby acknowledge that I have been provided the opportunity to review the Amor Telehealth Clinic Notice of Privacy Practices and that I have read and fully understand the notice. I have been provided with the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient/Guardian Signature: ---------- Date: ----------

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, pediatrists, 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 a good faith and, if licensed, the services provided were with in the scope of the licenses of the professional(s).
4. The professional(s) committed the act or omission while 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 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 Amor Telehealth Center Clinic in exchange for receiving free professional medical services.

I am aware that the practice of medicine is not an exact science and acknowledgment 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 during 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 Amor Telehealth Center Clinic. My consent is valid until I withdraw it.

Patient/Guardian Signature: ---------- Date: ----------