HEALTHY HAMILTON COUNTY WORKFORCE PILOT PROGRAM REGISTRATION AND CONSENT FOR WALK-IN SICK VISITS

Workforce Visits are Limited to Treatment for the Following Conditions Only:

- Coughs/Colds/Flu
- Ear and Eye Infections
- Sore/Strep Throat
- COVID-19
- Sinus & Respiratory Infections
- Urinary Tract Infections
- Rashes/Bites

Patients are seen on a first-come-first-served basis Monday-Thursday & Saturday and must arrive between 9:00-9:30am; during Cold and Flu Season you may experience long wait times. Pilot program ends March 2, 2023.

To receive services, you must have a PHOTO ID showing your date of birth and a CURRENT PAYSTUB from a business located in Hamilton County within the income guidelines below:

	Weekly	Bi-Weekly	Monthly	Annual
Income Limit:	$727 per week or less	$1,454 every two weeks or less	$3,150 per month or less	$37,800 per year

Employer_____ **Location/City**_____ **Occupation**_____

Patient Last Name_____ **First Name**_____ **Middle**_____

Gender ☐ **Female** ☐ **Male** **Date of Birth** ____/____/____ **Phone** (____)_____

[x] I give Trinity Free Clinic consent to call, text, and leave messages.

Home Address _____

Street Address *Apt #* *City* *Zip Code*

Language ☐ English ☐ Spanish ☐ Arabic ☐ Other_____ **Need interpreter?** ☐ Yes ☐ No **Country of birth**_____

Race/Ethnicity ☐ White ☐ Hispanic/Latino ☐ Asian ☐ African American ☐ Hawaiian/Pacific ☐ American Indian/Alaskan ☐ Other_____

PATIENT CONSENT

For and in consideration of medical treatment or consultation made available to me without charge at Trinity Free Clinic, Inc. ("Trinity"), I agree to the following:

1. I give my permission to Trinity Free Clinic, Inc. ("Trinity"), its agents and volunteers to treat me during this and subsequent visits and to provide medications, medical care and other services and supplies as are needed in the opinion of my treating provider for my health and wellbeing. I understand this may include, but is not necessarily limited to pathology, radiology, and other services and tests, including tests for communicable diseases, ordered by my treating provider.
2. I release, relieve and discharge from liability Trinity, its officers, directors, agents, non-clinical employees and non-clinical volunteers of and from all liability for any and all losses, injuries, or damages to either my person or to my property, occasioned by, in any manner growing out of, or as a direct or indirect result of my receipt of any services which Trinity has any responsibility or is made available by it. I understand Trinity may obtain access to or copies of my health records, regardless of the records location or who has the health records, for my treatment.
3. I give my permission for Trinity to find and use other health professionals in consultation/referral regarding my medical condition for the purpose of further health care. I am aware that Trinity cannot guarantee the care provided by a referral physician or health care specialist will be given to me free of charge and that Trinity is not responsible for payment.
4. By signing below, I authorize Trinity to provide a blood draw and testing for blood-borne infectious diseases, including, but not limited to hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV) if a physician orders such tests or if ordered by protocol. I understand the results of these tests will become part of my confidential medical record.
5. **I hereby acknowledge receipt of the following notice:** Under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner, board member, officer, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board member, officer, employee, or independent contractor who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)). The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

By signing below, I certify that I have read this **Consent and Release of Information** and the **Patient Rights and Responsibilities** (or have had the same read to me) and that I fully understand what I have read and have had all my questions about these forms answered to my satisfaction. I acknowledge I have voluntarily signed this Release as evidence of my intent and **agreement** to be bound by it. **Failure to sign WILL result in not being treated.**

_____ _____ _____

Patient Signature *Patient Guardian Printed Name* *Date*

Patient Visit Complete _____ **at** _____ _____

Date Time Provider Signature

Patient May Return to Work [ ] Immediately [ ] Tomorrow [ ] Other: _____

Rev: 12/5/2022