RURAL HEALTH
MEDICAL PROGRAM, INC

713 J.L. Chestnut Blvd
Selma, AL 36702
334-874-7428

Sliding Fee Eligibility Form

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in our center in strict confidence. You must verify your income at least every six months. Your yearly income tax return with a copy of your W-2 form, payroll check stubs covering the past six months, or copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

Do you receive any income from any of the following sources, and if so \, how much? Yes _____ No _____ $_____

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes, list below _____ No _____

Give Names, DOB, and SSN of all individuals living in the household.

Name:	Date of Birth	Social Security Number:

Today's Date:	Chart Number:	Clinic Purpose Only Income Code:

PATIENT INFORMATION

Patient's Last Name: First Middle	Marital Status (circle one) Single | Married | Divorced | Widow(er) | Separated

Date of Birth	Social Security Number:	Race:	Email address:
Address:	City, State		Zip Code:
Telephone Number:	Do you own, rent your home or live in public housing? (circle one) Own | Rent | Live with someone | Public Housing		Number of people living in your home?
Are you a veteran? Yes ☐ No ☐			Are you a **Female** ☐ or **Male** ☐

Amount of Household Income

You	Your Spouse	Your Children	Other Person

Place of Employment

You	Your Spouse	Your Children	Other Person
Employer phone no:	Employer phone no:	Employer phone no:	Employer phone no:
Do you have money in your savings account? Yes ☐ No ☐	Do you have money in your checking account? Yes ☐ No ☐	Do you have any rental properties? Yes ☐ No ☐	Do you own stock or certificates? Yes ☐ No ☐
How much? $	How much? $		

Do you receive any income from any of the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					

Retirement Pension					
Food Stamps					
Rental Income					
Interest Income					
Child Support, Alimony					
Other (Specify)					

List Dependent Children				
	Name	DOB	Social Security #	Other Proof Document
1.				
2.				
3.				
4.				
5.				
6.				

List Other Household Members					
	Name	Relationship	DOB	Social Security #	Other Proof
1.					
2.					
3.					
4.					

How Did You Hear About Us?

ŏFriend or Relative ŭNewspaper ŭInternet ŭTV ŭ Radio ŭBrochure

I declare the above information is true and have given the Rural Health Medical Program, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

_____ _____

Patient Signature Date

_____ _____

Employee Signature Date

_____ _____

Name of emergency contact person Phone number of emergency contact

UDallas County Health Center
228 Selma Avenue
Selma, AL 36702

UUniontown Health Services
330 Old Hamburg Rd.
Uniontown, AL 36786

UPine Apple Health Center
867 County Rd. 59
Pine Apple, AL 36726

UYellow Bluff-Camden Health Center
2210 Highway 221 N.
Camden, AL 36726

UMarion Health Center
1310 Washington St.
Marion, AL 36756

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RURAL HEALTH
MEDICAL PROGRAM, INC

YOUR RIGHTS:

You have the following rights regarding health information we have about you:

Right to inspect or copy: You have the right to inspect and copy, at your expense, health information that may be used to make decisions about your health care or payment for your care. This includes medical and billing records. To inspect and copy this health information, you must make your request in writing to the medical records clerk. All records will be copied within ten days from the original request. Copying fees are applicable according to the laws of the State of Alabama and payable in cash.

Right to Amend: If you feel the health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, you must make your request in writing to the medical record clerk.

Right to an Accounting of Disclosure: You have the right to request a list of certain disclosures we made of health information for purpose other than treatment, payment, and health care operations or for which you have provided written authorization. To request an accounting of disclosures, you must make your request in writing to the medical records clerk.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment, or health care operations. You may also have the right request a limit on the health information we disclose to someone involved in your care, like a family member or friend. For example, you may ask we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to the medical records clerk. We are not required to agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

_____ _____

Patient Signature Date

OVER

RURAL HEALTH
MEDICAL PROGRAM, INC

Acknowledgment of Privacy Act

I have read and understand the privacy policy of Rural Health Medical Program, Inc.
I have the right to request a copy of this policy for my personal records at any time.

I authorize this facility to release and/or discuss my medical information with (list below):

Please Print:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Patient or Legal Guardian's Signature	Date
_____	_____
Please Print Name	DOB

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Pine Apple, AL 36726

Yellow Bluff-Camden Health Center
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Camden, AL 36726

Marion Health Center
1310 Washington St.
Marion, AL 36756

RURAL HEALTH
MEDICAL PROGRAM, INC

Medical Records Release Form

By signing this form, I authorize Rural Health Medical Program, Inc. to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

HIV/AIDS: I consent to release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with rest of my medical records. Initial_____ Date: _____

The information you may release subject to this signed release form is as follows:

☐Complete Records	☐History & Physical	☐Progress Note	☐Care Plan
☐Lab Reports	☐Radiology Reports	☐Pathology Reports	☐Treatment Record
☐Operative Reports	☐Hospital Reports	☐Medication Record	☐Other (please specify below)

_____

_____

Release my protected health information to the following physician/person/facility/entity:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

The purpose/reason for this release of information is as follows:

_____

I understand that; I may revoke this authorization at any time and that unless an earlier date is specified. It will automatically expire 12 months after the date affixed below.

_____ _____
Patient Name (Please Print) Parent, Guardian, Authorized Representative

_____ _____
Patient's Signature Date If signed by Legal Representative, Relationship

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Marion, AL 36756

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Patient Disclosure Authorization Form

Patient Name: _____ Date of Birth: _____

I hereby permit disclosure of my protected health information only in the specific manner, for the named reason, and to the specific individuals(s) described below.

Specific description of information to be used or disclosed:

_____

_____

_____

(use additional sheet if necessary)

Reason for requested use or disclosure:

☐ Patient request (personal reasons)

☐ Employment related or to substantiate a disability claim

☐ Other _____

(use additional sheet if necessary)

Office staff at this practice authorized to disclose my information (if discloser is not at this practice, ask for assistance):

_____

Person(s) or entity(ies) to whom this practice will give my information:

Name _____ Address _____

This authorization will expire on the following:

☐ Date: _____

☐ Event (relating to patient or the purpose of this disclose: _____

_____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I may inspect or receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____

Relationship to Patient (if signed by a personal representative of patient):

_____ Date: _____

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