Open Door Clinic
of Alamance County

424 Rudd Street, Suite 102
Burlington, NC 27217
(336) 570-9800 Office
(336) 570-3376 Fax
info@opendoorclinic.net
www. opendoorclinic.net

Patient Eligibility Checklist

Patient Name: _____ Date: _____

Please complete the following forms and submit one item from each category below if pertaining to you. All forms and supporting documents are required at one time for the application to be considered complete.

Completed applications and supporting documents may be emailed to *info@opendoorclinic.net* or turned in to the clinic during clinic hours. An appointment will not be made until the application and all supporting documents are turned in.

1. Verification that you or the person you live with is an Alamance County resident.

_____ Current **North Carolina** driver's license or picture ID. No out of state IDs accepted.

_____ Current utility bill such as water, cable, electricity, natural gas or landline telephone bill, etc. **DATED** within the last 30 days.

_____ If you live in Liberty, Mebane, or Gibsonville, we will need an Alamance County tax bill, car registration, or food stamp award letter **DATED** indicated your **PHYSICAL** address.

_____ If you live in a group home or shelter, please provide a statement from that facility indicating that you are currently residing there.

_____ If you **DO NOT** have any of the above documents, we will accept a food stamp award letter.

_____ If you **DO NOT** have any of the above in your name, a notarized statement from the person you live with and their utility bill or food stamp award letter will be accepted.

2. Proof of Household Income

_____ Your two most recent pay stubs if you are working, verification of gross unemployment benefits, verification of child support, pensions, retirement, social security or disability checks. **Current bank statements showing direct deposits of benefits is acceptable.**

_____ If you filed taxes or are listed on taxes with a spouse, parent, or other family member, all family members receiving income will need to turn in their recent income as listed above.

_____ **If you have no income:** Provide a **NOTARIZED** statement from the person that supports you.

3. Taxes

_____ Current Federal Tax Return (1040) if you filed.

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Patient Registration Form

Patient Demographics

Patient's Full Name (First, Middle, Last)	**Date of Birth**	**Social Security Number**

Gender at Birth	**Gender Identity**	**Preferred Pronouns**	**Race**	**Ethnicity**

Preferred Language	**Do you need an interpreter?**	**Are you a veteran?**

Physical Address (Street and Unit Number)	**City**	**State**	**Zip Code**

Mailing Address (If different than above)	**City**	**State**	**Zip Code**

Home Phone Number	**Mobile Phone Number**	**Email**

Emergency Contact Name	**Relationship**	**Contact Number**

Household Information

Household Size	**Monthly Household Income** (Please circle the category that applies)			
1	$0-$1,215	$1,215-$1,823	$1,823-$2,430	$2,430-$3,038
2	$0-$1,643	$1,643-$2,465	$2,465-$3,287	$3,287-$4,108
3	$0-$2,072	$2,072-$3,108	$3,108-$4,143	$4,143-$5,179
4	$0-$2,500	$2,500-$3,750	$3,750-$5,000	$5,000-$6,250
5	$0-$2,928	$2,928-$4,393	$4,393-$5,857	$5,857-$7,321
6	$0-$3,357	$3,357-$5,035	$5,035-$6,713	$6,713-$8,392

Have you had health insurance or any health coverage in the last 90 days?	**How did you hear about us?**

Acknowledgement and Signatures

I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge. I hereby authorize the Open Door clinic to contact any person, firm or organization listed on this application to verify any of the information given. I hereby authorize any such person, firm or organization to release to the Open Door clinic any information it may request.

Patient Signature:	**Date:**

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Patient Registration Disclosures and Consent

Patient Name: _____

Consent of Treatment:
I attest that the above information is true to the best of my knowledge. If any documents are falsified ex: residency, income, etc. you will immediately be dismissed from the clinic. I hereby voluntarily consent to routine diagnostic and therapeutic procedure and general medicine is not an exact science and that there are no guarantees as to the results of the care delivered which I hereby authorize.

Release of Medical Records:
In the case of referrals, I hereby authorize the Open Door Clinic to release my pertinent medical records (Physician notes, x-rays reports, EKG's, lab reports, etc.), including any information regarding drug/alcohol abuse, HIV status and mental health, to the necessary physician's office, medical facility or hospital.

Patient Agreement:
I understand that the Open Door Clinic is a non-profit volunteer clinic. I agree to show respect to all clinic volunteers. I agree to keep all scheduled appointments both at the clinic and at referral appointments made by clinic staff. If I am unable to make an appointment, I agree to call and cancel or reschedule as soon as possible. I agree to bring all required eligibility verification. I agree to call in sufficient time for refill/sample requests. I understand that the clinic reserves the right to refuse or terminate service to any patient who does not comply with the above agreements.

Health Insurance Portability and Accountability Act "HIPAA":
I hereby authorize the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations. I understand the identity of designated parties must be verified before the release of any information. I also understand these parties will have access to all of my protected health information including substance abuse, mental health, STI, AIDS and HIV records.

Lab/X-Ray/Diagnostic Services:
I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services offered by a different health organization. I further understand that I am financially responsible for co-pay or balance due for these services provided outside of the Open Door Clinic.

Privacy Authorization:
I hereby authorize the Open Door Clinic to speak with the following persons regarding my appointments, care or instructions:

_____ _____
Name Relation to Patient

_____ _____
Name Relation to Patient

I further authorize the Open Door Clinic to leave messages on the voicemail or answering machine for the home and cell numbers given for my primary contact information. These numbers may be listed on the application, given during check-in/check-out or left on the Open Door Clinic voicemail.

☐ ***By checking this box, I do NOT authorize messages being left regarding my care or appointments with any other person. I do NOT authorize messages being left regarding my care or appointments with any other person. I do NOT authorize messages being left on the designated telephone or cell answering machine or voicemail.***

_____ _____ _____
Patient Signature Witness Signature Date