Welcome to The Mercy Ministries. You have recently been approved medically to become a patient. This approval is pending until the enclosed new patient information is completed and the financial documents provided are reviewed. Please return all of the required information to the clinic in-person, by mail or fax.

The following must be submitted BEFORE your initial appointment at the clinic with a provider will be scheduled:

- **All enclosed forms must be completed and signed**
- **All documents for proof of income** (tax return, food stamp benefit letter, 3 months of current check stubs if employed, or if spouse is employed)
- **Copy of Picture ID**
- **Copy of Social Security Card**

A Medicaid denial letter is also required but will not interfere with your initial appointment; however, in order for us to order medications for you, a Medicaid denial letter will be required. No medications will be ordered until it is received.

In our effort to provide excellent service and to be efficient with our funding and limited times of operation, this new patient packet is required. We do not prescribe any narcotics in our clinic. If you are in need of these we will not be able to prescribe them. If you have any questions about any of the enclosed forms, please feel free to call us at the numbers below. Thank you again for your interest in becoming a patient. We are looking forward to partnering with you!

Blessings,
The Mercy Ministries Team

Main Campus
714-1 NW Broad St.
Lyons, GA
(912) 524-4000 Ph
(912) 524-4004 Fax

Graham Campus
448 Vernon Williams Rd.
Hazlehurst, GA
(912) 705-8801 Ph
(912) 705-8851 Fax

New Patient Information
Demographics & Household Info

Patient's Legal Name:_____

Name you would like to be called:_____Male/Female (please circle)

SSN_____Marital Status: M W D S (please circle) Race/Ethnicity_____

Address:_____

City_____State_____ZIP_____

County_____

Home Phone:_____Cell_____Work_____

Patient's Employer_____

Employer's Phone #_____

Patient's Email Address_____

Spouse's Employer_____

Spouse's Phone Number_____

Emergency Contact Name_____Phone #_____

Relationship to patient_____

Drug Store Preference_____

Number of Members in your household_____Number of Disabled Children in your custody_____

Please list your spouse and legal dependents who currently live with you:

Name	Relationship	Age

By signing below, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers.

_____ Date_____

Patient's Signature

Are you employed? Yes No

Employer Name_____Address_____Phone #_____

Is your Spouse employed? Yes No

Employer Name_____Address_____Phone #_____

Do you receive a check from Social Security? Yes No

How much?_____ (copy required if yes)

Does your spouse receive a check from Social Security? Yes No

How much?_____ (copy required if yes)

Do your children receive a check from Social Security? Yes No

How much?_____ (copy required if yes)

Does your spouse receive other retirement pension? Yes No

How much?_____ (copy required if yes)

Do you receive unemployment compensation? Yes No

How much?_____ (copy required if yes)

Do you receive workers compensation? Yes No

How Much?_____ (copy required if yes)

Do you receive child support/alimony? Yes No

How Much?_____ (copy required if yes)

Do you receive food stamps? Yes No

How Much?_____ (copy required if yes)

Any other income? Yes No

How Much?_____ (copy required if yes)

Are you a veteran? Yes No

Signature_____ Date_____

New Patient Information
Medical History

Name:_____DOB_____

Please list all current medical problems:

_____
_____
_____
_____

Please list any drug allergies:

_____
_____
_____

Please list all current medications: (include dosage and how often you take them and also include any over the counter medications)

_____
_____
_____
_____
_____

Do you require medication prior to dental procedures or any procedures? Y/N

Please circle if you have had any of the following:

Heart Disease/ Heart Attack	Cancer (type)_____	Mental Illness
Stroke	Allergies	Bleeding Problems
High Blood Pressure	Kidney Stones	Alcoholism
Diabetes	Tuberculosis	Asthma
Colon Polyps	AIDS	Other_____

Please List all past surgeries:

_____
_____
_____
_____

Have you ever had a joint replaced or heart valve replaced? Y/N

New Patient Information
Family & Social History

FAMILY HISTORY: PLEASE CIRCLE IF ANY <u>BLOOD RELATIVE</u> HAS HAD ANY OF THE FOLLOWING:

Heart Disease/ Heart Attack

Stroke

High Blood Pressure

Diabetes

Colon Polyps

Cancer (type)_____

Allergies

Kidney Stones

Tuberculosis

AIDS

Mental Illness

Bleeding Problems

Alcoholism

Asthma

Other_____

	LIVING	DECEASED	AGE	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS				
SISTERS				

SOCIAL HISTORY:

MARITAL STATUS: S / M / D/ W

Do you get any regular exercise? Y/N

Do you currently use any type of illegal drug? Y/ N If yes what type _____

Have you used any type of illegal drug in the past? Y/N

Alcohol use? Y / N How often and how much? _____

Tobacco Use: Cigarettes Y/ N if yes please circle one of the following:

More than a pack a day A pack per day less than a pack per day ____cigarettes per day

Smokeless tobacco : Y/N How much per day?_____

Former Smoker: How long quit?_____ How long did you smoke? _____

Former smokeless tobacco: How long quit: _____ How long did you use tobacco? _____

HEALTH MAINTENANCE: Have you had any of the following test in the past?

Colonoscopy Y/N Date:_____ Mammogram Y/ N Date: _____ Pap Smear Y/N Date:_____

PSA (lab for prostate cancer screening for males) Y/N Date:_____

Mercy Client Contract

Welcome to the Mercy Ministries. We are excited that you have taken the first step to wellness in your life. The Mercy Ministries is a non-profit, faith-based organization with a desire to help members in our community to start a journey to wholeness. We are able to offer free services or services with a minimal fee because of private donations and funding provided from our community. Because of this partnership we ask you to sign a client contract that states you will be responsible for taking certain steps to get better and move forward. *(Please initial each statement below and sign at the bottom.)*

⇒ _____ Mercy Ministries utilizes the services of several volunteers. Crude behavior will not be tolerated. If you become frustrated, ask for a manager. We will be glad to assist you. Be respectful, be patient with our staff and volunteers.

⇒ _____ We have a great partnership with our local physicians , because of this partnership we ask that if you have an appointment with one of these physicians that you please show up on time, and that you are respectful to their staff. Crude behavior will not be tolerated at your specialty appointment. If you are a "No Show" or if your behavior is disrespectful during any of your specialty appointments you will be dismissed from our program.

⇒ _____Mercy Ministries DOES NOT prescribe narcotics or sign off on narcotics written by other providers.

⇒ _____I am aware that referrals for test, labs, surgery, specialty care and some medications at pharmacies are not FREE and are NOT covered by The Mercy Ministries.

⇒ _____ I will be responsible for applying for indigent care at the hospital for test that require this.

⇒ _____ If I receive any bills from Meadows, Doctor's office or a lab, it is my responsibility to call the number and research the amount owed and set up payments. If I am unable to understand after initial contact with the billing company, I can call Mercy for guidance.

⇒ _____ I understand that Emergency Room visits should be limited to emergencies only. Examples of emergencies are not limited to but are similar to the following: chest pain, one sided weakness or paralysis, injury, difficulty breathing or severe headache without relief. The Mercy Medical clinic does NOT offer emergency care services, if you believe you are experiencing a medical emergency you need to report to the nearest emergency room. For colds, sore throat, flu-like symptoms, and recurrent chronic pain please contact the clinic first and we will advise you and make an appointment as soon as possible. If you do visit the Emergency Room during operational hours of the clinic for anything not considered an Emergency and do not call the clinic first we will not cover any medications prescribed.

⇒ _____ I understand that financial review will be required every year, and I will provide the financial requirements within 7 days of the request. Failure to provide will result in delay of receiving medications .

⇒ _____ 2 or more No Show appointments within 1 year will result in dismissal from the program. After your first No Show appointment to TMM you will be required to have an accountability appointment.

⇒ _____ I must be evaluated in the office by a provider every 6 months in order to continue to receive refills on medications. I must be evaluated within a year in order to continue to be an active patient, if we have not seen you within a year you will be considered an inactive patient and will have to re-apply.

Mercy Client Signature: _____Date: _____

Mercy Staff Witness Signature: _____ Date: _____

You will receive a signed copy and the original will be placed on the clients records.