Community Health Services of Union County, Inc.

Free Clinic Screening Form

Name: _____ **Date of Birth** _____

Mailing Address: _____ **Zip Code:** _____

Email address _____

Phone: (H)_____ **(C)**_____ **Gender:**____**Male** ____**Female**

Employer Name: _____ **Retired** ___ **Unemployed** ___ **Disabled** ___ **Number in household:** _____

Race: ☐**Asian** ☐ **Black/Afr. Amer.** ☐ **Hispanic/Latino** ☐ **Multi-Racial** ☐ **Native American** ☐ **White** ☐**Other**

Income: ☐ $0 to $9,999 ☐ $25,000 to $34,999 ☐ $75,000 to $99,999 ☐ $150,000 to $199,999

☐ $10,000 to $14,999 ☐ $35,000 to $49,999 ☐ $100,000 to 149,999 ☐ $200,000 or more

☐ $15,000 to $24,999 ☐ $50,000 to $74,999

Health Insurance Coverage (please check all that apply) ☐ **Medicare** ☐ **Medicare Supplement**

☐ **Medicaid** ☐ **Private Insurance** ☐ **NC Health Choice** ☐ **None**

The last time I saw a healthcare provider was _____. I certify that I am not now under the care of a Primary Health Care Provider. Signature_____Date_____

Consent and Release for Drawing of a Blood Sample

I consent to the drawing of a blood sample for requested blood work. I release Community Health Services and any other organization(s) associated with this screening from any and all liability. I understand that:

(1) This test is for screening purposes only and a diagnosis cannot be made from it.
(2) The CHSUC nurse will discuss the results with me.
(3) My results are confidential and will not be given to anyone outside of CHSUC without my written permission.

Signature:_____ **Date** _____/_____/_____

Initial_____ **Date** ___/___/___ **Initial**_____ **Date** ___/___/___ **Initial**_____ **Date** ___/___/___ **Initial**_____ **Date** ___/___/___
Initial_____ **Date** ___/___/___ **Initial**_____ **Date** ___/___/___ **Initial**_____ **Date** ___/___/___ **Initial**_____ **Date** ___/___/___

AUTHORIZATION FOR COMMUNITY HEALTH SERVICES TO RELEASE INFORMATION

TO WHOM IT MAY CONCERN:

This is to authorize Community Health Services, its affiliates, agents, and employees to release any and all records, documents, information, or opinions which may be requested regarding my medical and/or financial condition to any person, firm, agency, or organization as to which such information appears to Community Health Services to be reasonable or necessary to enable myself and/or my family to obtain medical, financial, and/or rehabilitative assistance.

Signature_____ **Date**_____