Approved by OMC Board on October 27, 2020, for immediate implementation.

Outpatient Medical Center, Inc.
Application for Discounted Services

PLEASE PRINT CLEARLY

APPLICANT'S NAME (LAST, FIRST, MIDDLE)		HOME TELEPHONE NO.	DAY PHONE: (WORK TELEPHONE NO.)		ALTERNATE PHONE: (CELL PHONE)
Billing Address (Street or P.O.Box)	Appt #	City	State	Zip	County
Secondary Address (Physical)					
Have you ever used another name: (Previous Last, Nickname) ☐ Yes ☐ No		Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated			

Fill in line (a) about yourself. List below every person who lives in the same household as you:

Name (Last, First, Middle)	What Relationship to you	Date of Birth	Sex	Race (see below)	Ethnicity (see below)	Social Security Number
Applicant (a)	SELF					
(b)						
(c)						
(d)						
(e)						
(f)						
(g)						

Race	Ethnicity
A – Asian B – Black/African American MOR – More Than One Race NA – American Indian/Alaskan Native NH – Native Hawaiian OPI – Other Pacific Islander U – Unreported/Unknown W - White	LH – Latino or Hispanic NH – Not Hispanic U – Unknown Ethnicity

List all of your household's income below:

Name of Person Working or Receiving Money	Name of Employer, Person, or Agency that Provides Money	How Often Received	Amount Received	Social Security, Social Security Disability, TANF, Self-Employment (Enter Claim No.)
TOTAL INCOME			$	

Does anyone have health insurance? (Private Insurance, Medicaid, Medicare, CHIP, Etc.) If so, please list below.

Name of Person Insured	Name of Policy Holder	Name of Employer Providing Insurance	Name of Insurance	Policy Number	Ins. Co Telephone Number

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief.

I agree to give OMC Clinics eligibility staff any information necessary to prove statements about my eligibility. I will cooperate fully with a quality control review or audit.

I agree to report any of the following changes within 14 days:

- Income
- Number of people who live with me
- Address
- Application for or receipt of SSI, TANF or Medicaid.
- Name/Address/Telephone

I understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt of stopping assistance.

I understand that by signing this application, I am giving OMC the right to recover the cost of health care services provided by OMC from any third party. I agree to give OMC any information required to identify and locate all other sources of payment for health care services.

If I qualify for discounted services and it is later determined that the information or proof I provided on this application is false, I may lose my discount, may be barred from reapplying for six months, and may be required to repay OMC for any services rendered at 100% of cost. I understand that my failure to meet the obligations set forth may be considered willful withholding of information and can result in the recovery of any loss by repayment, or by filing criminal or civil charges against me.

BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT

_____ _____

Signature – Applicant **Date**

END OF PATIENT INFORMATION
*****DO NOT CONTINUE*****

COMPLETED BY PATIENT SERVICES SPECIALIST DURING FINANCIAL SCREENING

ONE DAY PASS (IF APPLICABLE) Today's Date: _____

Today you are being issued a one day pass and you will be responsible for %100 of ALL fees associated with services provided on this date. In order to update your file, you must provide the following: Refer to Checklist for Financial Screening ____ID ____Residency____Income ____Coverage

_____ _____

Signature of Patient Witness

FINANCIAL SCREENING OUTCOME Today's Date: _____

Based on the information you submitted to us, we are pleased to inform you that we have established your eligibility for service, effective from _____to_____. Your discounted rate is _____% of charges billed, in addition to any approved OMC fees for each medical and/or dental visit, and a prescription dispensing fee for each.

ACKNOWLEDGEMENT OF RECEIPT

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge and agree that I have received a copy of my rights and responsibilities as a patient. I understand that if I neglect to fulfill my responsibilities that I may be terminated as a patient of the clinic.

_____

Patient's Initial

NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received a copy of OMC's Notice of Privacy Practices, By signing this form, I consent to OMC's use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

_____

Patient's Initial

CONSENT TO TREATMENT

I consent to any X-Rays or laboratory examination; anesthesia; and medical, surgical or dental treatment rendered by Physicians, Physicians in Specialty Training, Dentists and designated clinic personnel, including Physician's Assistants and Nurse Practitioners (whom I understand are not licensed Physicians and may not treat or diagnose any illness, injury, or medical condition except under the supervision and direction of a Licensed Physician), Registered Nurses, Licensed Vocational Nurses, Medical Aides, Technicians, Pharmacists, Dietitians, Health Educators, Health Care Professions students and any other persons who are not licensed Physicians or Dentists but who are deemed by the Physicians or Dentist to be trained to assist under the general and special instructions provided by them. I further understand that I may revoke this authorization at any time.

_____

_____

Signature of Patient or Legal Representative Date

_____ _____

Description of Legal Representative's authority to act for patient *(if applicable)* Witness

THIS APPLICATION WAS REVIEWED BY:_____

FINANCIAL SCREENING SPECIALIST