

***2025 AGREEMENT TO TERMS OF SERVICE & INFORMED CONSENT***

*Please read the following document. After reading each item, initial the line beside the statement and sign and date the last page.*

**\_\_\_\_\_\_MISSION/VISION STATEMENT:** Our mission is to provide primary medical and dental care and prescription medications to qualified uninsured adults in Rowan County. Our vision is to ensure that healthcare is available to all Rowan County residents through service provision and/or collaboration with other resources.

**\_\_\_\_\_\_ELIGIBILITY:** All patients must qualify for services upon initial visit and **every 90 days thereafter**. Proof of eligibility for 90-day update includes the following:

* All household income (wages, unemployment, pension, Social Security retirement, Social Security disability, child support) (every 90 days). **Household income refers to the combined gross income of all members of a household, defined as a group of people living together, who are 15 years or older.**
* Proof of Rowan County residency (a recent document providing residency in Rowan County). Accepted documents include utility bill (gas, water, electricity) and/or rental or lease agreement.
* A Medicaid denial from the Department of Social Services. If you have Family Planning Medicaid, we must have the letter stating that is for family planning only (annually) and a copy of the Medicaid card.
* If you are actively seeking disability, this must be verified by a letter from the Social Security Administration or your attorney (every 90 days).
* 1040 Form for federal taxes (If you file taxes, you must share this document. The drug companies will notify us of your filing and will deny your prescription assistance application.)
* **The clinic requires a $10.00 non-refundable administrative fee per quarter. Patients can pay the $40 for the year or $10 per quarter.**
* After all eligibility is updated and the administrative fee has been paid, a yellow eligibility card will be issued to the patient for 90 days. **This card must be presented to receive medical, dental and pharmacy services each time services are rendered and/or a prescription is picked up. If you do not update, your eligibility will be locked and you will not be able to pick up your prescriptions or receive services until your eligibility is updated.** If you need to send a friend or a family member to pick up your medicine, please send your yellow card with them so we know that they have your permission to pick up your prescriptions.
* If you receive full Medicaid coverage at any time this year, please let the clinic know immediately.

\_\_\_\_\_\_\_\_Eligibility requirements are set by what drug companies require in order for patients to receive free medications. The following information may be needed for this program: name, SSN, DOB, income, address, income taxes, Medicaid denial, phone number and medical records. Additional documents may be required.

**\_\_\_\_\_\_** **SERVICES:** It is the purpose of the Community Care Clinic of Rowan County to provide a high standard of primary care and there will be limitations on services we can provide. We are a non-profit organization that operates using paid/volunteer professionals, skilled support staff and donations from the community. The CCC does not offer services such as DOT physicals, disability evaluations, gynecology and/or pregnancy/STD testing.

**\_\_\_\_\_\_APPOINTMENTS:** Patients are to call the Community Care Clinic at 704-636-4523 in order to schedule an appointment. **Please call the clinic for a sick appointment before going to the Emergency Department**. All scheduled appointments are given on a first call/first come basis. Upon arrival for all appointments, please check in at the front desk.

**\_\_\_\_\_\_REFERRALS:** Visits to the Community Care Clinic are free of charge. **There is no guarantee for any free service outside of the clinic.** This includes referrals, diagnostic testing or screenings. If the physician makes a referral, a consent form will be required for that visit; however, this does not mean the service will be free. It is your responsibility to confirm cost with all outside referrals. The Community Care Clinic is not responsible for Emergency Department bills.

**NO PRESCRIPTIONS CAN BE PICKED UP WITHOUT A PHARMACIST ON DUTY**!

*(This is a North Carolina state law)*

\_\_\_\_\_\_\_\_The pharmacy is open Mon - Thurs from 9am-12pm and 1pm-4pm. Prescription refills must be called in **1-2 BUSINESS DAYS** prior to pick-up. Refill requests may be phoned-in 24 hours a day using the refill line. Please **DO NOT** wait until you are out of medicine to request refills.

\_\_\_\_\_\_\_Please note that you will occasionally receive mail from drug companies stating that you have been accepted into their program and a 90-day supply of medications was shipped directly to your physician. All medications should be shipped directly to the Community Care Clinic, **not to your home**. Do not complete any forms for medications you receive through the mail. Any telephone calls from the drug companies should be directed to the clinic. Clinic staff will complete all necessary paperwork for you. **If you receive any of the following from drug companies at home, you must bring to the CCC pharmacy staff IMMEDIATELY:**

* Medications
* Rejected applications/denial letters from drug companies
* Request for additional information

**\_\_\_\_\_\_\_Weapons (including knives and guns) and illegal substances are NOT ALLOWED on the premises. If you are in possession of either, the police will be informed, and you will be immediately discharged permanently from all clinic services.**

**\_\_\_\_\_\_\_**The Community Care Clinic reserves the right to refuse service to anyone under the influence of drugs, alcohol, or exhibiting disruptive behavior. This includes clinic visits and telephone calls to the Community Care Clinic. ***Rude, vulgar or angry behavior will not be tolerated.***

**\_\_\_\_\_\_**Patients are expected to arrive on time. Please make every attempt to leave children at home. **Children are not to be left unattended in the waiting area**. Eating and drinking are not allowed in patient areas.

\_\_\_\_\_\_Please do not bring your cell phone into the patient treatment areas. If you must, it is required that they be turned off. No exceptions.

\_\_\_\_\_\_**Patients are required to wear face masks in the clinic when they are sick and let the staff know immediately. This will ensure that the staff has safety measures in place.**

\_\_\_\_\_\_\_**SUSPENSION OF SERVICES:** Failure to comply with a physicians’ treatment plan may result in dismissal from the clinic. This may include:

* Seeing two primary care physicians
* Failure to attend screening/referral appointments (this includes ***ALL*** appointments)
* **Failure to get lab work done** or non-compliance
* Falsification of any information provided **(failure to report changes in income, ability to obtain health insurance through a spouse, or moving/living in another county)**
* **If you are a no show for any appointment without calling to cancel in advance, you will not be eligible for any clinic services for 6 months. If you reschedule an appointment more than three times without attending in a 12-month period, you will be subject to no service for 6 months.** A letter will be sent to your home address on record to explain suspension of service (you can unlock for $10 – maximum one time per year).
* If you do not give 24 hours prior notice to cancel and/or reschedule **dental appointments**, you will not be eligible for **dental services** for 6 months. After 3 failed appointments, you will be dismissed from the dental clinic.
* If you are caught selling or giving others your medications, test strips or anything else prescribed for you, you will be discharged ***PERMANENTLY*** from the clinic.
* Failure to pay $10 non-refundable administrative fee quarterly

**\_\_\_\_\_\_\_**I acknowledge that the above has been explained to me to my satisfaction and I voluntarily consent to be examined and evaluated by the medical staff at the clinic. I also agree for routine tests to be done as necessary and treatment as indicated. The physician and/or nurse will discuss with me any treatment plan considered. I will comply with all services provided and understand my consequences if I do not.

**THE CCC IS HERE TO PROVIDE FREE *PRIMARY* MEDICAL AND DENTAL CARE TO PATIENTS.** There will be times that we are unable to treat your need if it is out of the scope of our primary practice.

Name *(please print clearly)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have read and agreed to the statements on the 2025 Agreement to Terms of Service and Informed Consent by initialing each item. My questions have been answered to my satisfaction.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date