FAITH FAMILY
MEDICAL CENTER

Nashville's source for affordable, high-quality healthcare

Serving the working uninsured and underinsured

How We're Different

Faith Family Medical Center is dedicated to being a place where hope and healing are available to all–where the well-being of the whole person–body, mind and spirit–is the focus of care.

Who We Serve

We serve the hard-working people of Nashville who deserve high-quality healthcare, and need to make every dollar count. If you don't have health insurance or if you have insurance that isn't helping you afford the medical care you need, Faith Family Medical Center is here for you. Children of qualified patients, over the age of two, can also be seen by our staff.

Patient Qualifications

- Working an average of 20 hours per week; a dependent of someone who is working an average of 20 hours per week; or a full-time student.
- Does not currently have government subsidized insurance such as Medicare, Medicaid (TennCare) or TriCare.
- Patients with insurance must not exceed the following income limits:

Household Size & Income

(Only applies to patients with insurance)

1	Up to $47,080
2	Up to $63,720
3	Up to $80,360
4	Up to $97,000

Cost

Faith Family Medical Center uses a sliding scale based on income and number of dependents to determine the cost of visits. Patient visits can range from $20–$55 per visit.

In order to provide our patients high-quality healthcare at the lowest possible cost, we depend on grants and donations from caring individuals, foundations, churches and businesses.

Services

Primary Care

From annual check-ups to sick visits, health screenings to vaccinations, we offer our patients a healthcare home they can count on.

Behavioral Care

Our staff focuses on keeping our patients healthy—mind, body and spirit. A psychiatric nurse practitioner is on staff to address behavioral healthcare needs.

Lab Tests & Prescriptions

We offer the comprehensive services needed to properly diagnose health issues and effectively manage treatments alongside our patients.

Wellness Programs

Journey to Health is a wellness program designed to educate, guide, and encourage a healthy lifestyle and is available, for free.

Faith Family Medical Center | 326 21st Avenue North | Nashville, TN 37203 | 615-341-0808

FaithMedical.org

FAITH FAMILY
MEDICAL CENTER

Date:	

Please complete this form to the best of your ability and as completely as possible. All of the requested information is needed to provide you and your family with medical care at our Center.

APPLICANT INFORMATION

First Name	MI	Last Name	Date of Birth	Sex	Marital Status
				M F	

Mailing Address: Street	City	State	Zip	Primary Phone #

Social Security Number	Email Address	Employer Name & Address

Employer Phone	Hours Worked Weekly	Average Monthly Earnings	I work: (Circle One)	
			Full-time	Part-time

SPOUSE INFORMATION (If applicable.)

First Name	MI	Last Name	Date of Birth	Sex	Marital Status

Home Address: Street	City	State	Zip	Home Phone #

Social Security Number	Employer	Employer Address

Employer Phone	Hours Worked Weekly	Average Monthly Earnings	I work: (Circle One)	
			Full-time	Part-time

DEPENDENTS (Must be living with you in your home.)

Name	Age	Birth Date	Social Security Number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Do you have health insurance? Yes No
Are you covered by Medicaid, TennCare (Medicare), or TriCare insurance? Yes No
Do you have an Advanced Directive? Yes No

PLEASE COMPLETE BACK SIDE OF FORM.

FAITH FAMILY
MEDICAL CENTER

Have you signed up for our new complimentary* text reminders regarding your appointment?

Our new texting service is designed to help you with important information regarding your appointment:

- Notify you in advance of your upcoming appointment.
- Notify you of changes in our clinic hours (i.e., due to severe weather).

The system is set up for two-way communication, meaning you are able to text the Center if there is a problem with your appointment, if you prefer not to call.

Please check the box and fill in the blanks.

1. I would like to sign on to your texting service (check box) ☐
2. Name _____
3. Mobile number _____
4. Date_____

IF THERE ARE ANY PARTICULAR PERSONS YOU WOULD ALLOW TO RECEIVE YOUR MEDICAL INFORMATION, PLEASE INDICATE BELOW:

_____ _____

_____ _____

Whom may we contact in case of an emergency?

Name_____ **Phone** _____

The information I have provided on this form is true and accurate to the best of my knowledge. I understand that Faith Family Medical Center furnishes care only to those individuals that qualify for services under the Center's guidelines regarding health insurance status, family income, and family size. I understand that if I am accepted for care at the Center, I will be responsible for an affordable co-payment for each visit made to the Center by myself and/or a member of my immediate family. If I am accepted by the Center, I agree to follow all the Center regulations and guidelines.

Your Signature **Date**

I have been offered a copy of Faith Family Medical Center's Notice of Privacy Practices for my own records.
Initials:_____

How did you hear about Faith Family Medical Clinic? _____

_____

_____

*Standard data and messaging rates may apply.

Faith Family Medical Center
326 21st Avenue North
Nashville, Tennessee 37203

DATE: _____

PHONE: _____

PATIENT INFORMATION

Name	Birth Date	Age	Religious Affiliation
Occupation	Reason for Visit _____		
Race	Ethnicity		Language

HOUSEHOLD STATUS (spouse, children, other family members living in your home?)

_____

_____

PERSONAL MEDICAL HISTORY (Please check past or present history of the following conditions:)

Past	Present	Condition	Past	Present	Condition
☐	☐	**Abnormal Pap Smear or Mammogram**	☐	☐	**Hernia**
☐	☐	**AIDS/HIV**	☐	☐	**High Blood Pressure**
☐	☐	**Alcohol/Drug Problems**	☐	☐	**High Cholesterol**
☐	☐	**Anemia/Bleeding Problem**	☐	☐	**Infertility (difficulty getting pregnant)**
☐	☐	**Arthritis/Gout**	☐	☐	**Kidney/Bladder Problems**
☐	☐	**Blood Clots**	☐	☐	**Liver Disease/Jaundice/Hepatitis**
☐	☐	**Cancer (Type:_____)**	☐	☐	**Mental Trouble/Depression/Anxiety**
☐	☐	**Cataracts/Vision Loss/Glaucoma**	☐	☐	**Rheumatic Fever**
☐	☐	**Circulation Problems**	☐	☐	**Seizures/Fits/Epilepsy**
☐	☐	**COPD/Emphysema/Asthma/Pneumonia**	☐	☐	**Serious Injury/Accident**
☐	☐	**Diabetes (sugar)**	☐	☐	**Sickle Cell Anemia**
☐	☐	**Eating Disorder (anorexia/bulimia)**	☐	☐	**Skin Disorders**
☐	☐	**Genital Herpes/Infections/Warts/GC**	☐	☐	**Stroke**
☐	☐	**Hay Fever/Pollen Allergy**	☐	☐	**Thyroid Problem**
☐	☐	**Headaches**	☐	☐	**Transfusion (year:_____)**
☐	☐	**Hearing Loss**	☐	☐	**Tuberculosis (TB)**
☐	☐	**Heart Attack/Heart Disease**	☐	☐	**Ulcers**
☐	☐	**Heart Murmur**	☐	☐	**Other (specify:_____)**
☐	☐	**Hemorrhoids/Polyps (Colon)**			

PAST SURGERIES, SERIOUS INJURIES, OR PREGNANCIES

_____
_____
_____

PERSONAL HABITS:
Past or present use of tobacco products? □ Yes □ No
(If so, please list what kind, how much, how long, and date last used.)

_____

Past or present use of alcohol? □ Yes □ No
(If so, please list how much and how often.)

_____

Past or present use of street drugs? □ Yes □ No
(If so, please list what kind and how often.)

_____

Do you have an advanced directive? □ Yes □ No

_____

FAMILY MEDICAL HISTORY: (Cancer, heart trouble, high blood pressure, diabetes, TB, blood problems, any other problems in parent, grandparents, siblings, and/or children)

_____
_____
_____

ALLERGIES:

_____
_____

MEDICATIONS PRESENTLY BEING USED: (prescriptions, over-the-counter, and/or alternative)

_____
_____
_____

IMMUNIZATIONS: Last Tetanus? _____ Pneumovax? _____
WOMEN ONLY: Last PAP Smear? _____ Last Mammogram? _____

FAITH FAMILY
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Who We Are

Faith Family Medical Center is a non-profit primary care center for individuals who are uninsured or underinsured. Faith Family Medical Center is primarily funded by donations. The office visit fee you pay covers only a small portion of the costs of your services. The rest is paid for by the generous contributions of others. We will treat you with respect and care and ask you to be respectful and courteous to us.

Initial/Date:_____

Patient Responsibility

FFMC Staff are here to help you receive the best care and treatment. We need your participation and cooperation to ensure this. Your obligations, as the patient, are listed below:

- **Be respectful and courteous to Faith Family staff at all times, including phone calls.**
- Update your proof of income once a year and/or if your income changes.
- Update your information (phone number and address) as it changes.
- Pay your office visit fee at the time of your appointment.
- Arrive 15 minutes prior to your appointment to update paperwork (if you are a new patient allow 30 minutes) **if you are late for your appointment you will be rescheduled for another day.**
- Medication Requests and Refills
    - For medication refills at your local pharmacy, call at least **1 week BEFORE** medication runs out to ensure you receive refills on time. Medication and refill requests have a minimum of 1 business day of processing time. Waiting until the day you run out will not speed up the processing time.
    - For medications refilled through our patient assistance program, call at least **2-3 weeks BEFORE** medication runs out to ensure you receive refills on time.
    - Provide your pharmacy number.
    - Know what medicines you are taking and why.
- Allow up to 7 days to receive lab results before calling. Multiple calls will only delay our ability to respond to your request.
- Attend each and every scheduled appointment with a provider, specialist, and/or nurse. If you cannot keep your appointment, please cancel at least 24 hours before your appointment time. Failure to cancel before your appointment time results in a no show. Three no shows within a 12 month period will result in being discharged from our center.
- As a courtesy, you may receive a reminder call from our volunteer, but it is your responsibility to record and attend all scheduled appointments.

I understand my obligations as a patient at Faith Family Medical Center. I understand that failure to comply with these obligations may result in termination from this practice.

Signature:_____ Date:_____

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