Client Application

Experience Freedom • Discover Hope

a ministry of HopeQuest™ ministry group, inc.

Office: 678-391-5950 Fax: 678-391-5969

Email: emily.woodfin@hopequestgroup.org

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MEN'S PROGRAM

Admissions Checklist

1

❍ Submit completed application and copy of your Driver's License and Insurance Card

2

❍ Send in TB Test results and Background Check from local sheriff's department ***(Online background checks are not accepted)***

3

❍ Schedule your Phone Interview and send back your Welcome Packet Agreement once you are approved

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MEN'S PROGRAM

Program Application

First	Middle	Last	
SS#		Marital Status	
Date of Birth		Race	
Address			
City		State	Zip
Phone		Email	

Relevant Contact Information

(spouse, physicians, therapists, psychiatrists, attorney, probation officer, etc.)

Name		Relationship	
Address			
City		State	Zip
Phone		Email	

Name		Relationship	
Address			
City		State	Zip
Phone		Email	

Name		Relationship	
Address			
City		State	Zip
Phone		Email	

PLEASE ATTACH LIST IF FURTHER CONTACTS NEED TO BE SHARED

Insurance Information

Insurance Company			
Member Number		Group Number	
Primary Policy Holder ☐ SELF			
Name		Date of Birth	
Address			

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MEN'S PROGRAM

Applicant Agreement:

- Detox from all drugs and alcohol for a minimum of 72 hours prior to admission
- The $500 non-refundable bed deposit will go toward the total tuition.
- Tuition must be paid in full at the time of admission.
- A 4% credit card processing fee will be charged for all credit card payments.
- It costs HopeQuest roughly $75,000 to put a client through the program. Each client receives a grant of $45,000, at a minimum, reducing the portion they are responsible for to $30,000.
- In the event a participant leaves the ministry program, for any reason, including dismissal, all deposits, tuition and program fees paid are non-refundable.

I have read and understand the above policies of The HopeQuest Ministry Group, Inc.

_____ _____

Print Name Date

_____

Signature

Woodstock Health Mart® PHARMACY

HOPEQUEST PATIENT INFORMATION

PATIENT INFORMATION

LAST NAME		FIRST NAME		M.I	
DATE OF BIRTH		LAST 4 SSN		GENDER	☐ MALE ☐ FEMALE
ADDRESS				APT #	
CITY		STATE		ZIP	
HOME PHONE		CELL PHONE			

INSURANCE

DO YOU HAVE ANY PRESCRIPTION INSURANCE?	☐ PRIVATE	☐ MEDICARE	☐ MEDICAID	☐ NO	
INSURANCE BIN #		INSURANCE ID #		PCN #	
RX GROUP #		INSURANCE NAME			

RESPONSIBLE PARTY INFORMATION

LAST NAME		FIRST NAME		M.I	
ADDRESS				APT #	
CITY		STATE		ZIP	
HOME PHONE		CELL PHONE			

PAYMENT INFORMATION

CARD TYPE	☐ VISA	☐ MASTER CARD	☐ AMERICAN EXPRESS	☐ DISCOVER
NAME ON CARD			BILLING ZIP	
CARD NUMBER		EXP DATE	CVV2	

MEDICAL INFORMATION

KNOWN ALLERGIES & DRUG REACTIONS

- ☐ NO KNOWN ALLERGIES/DRUG REACTIONS
- ☐ ASPRIN
- ☐ CEPHALOSPORINS (ex: KEFLEX, CECLOR)
- ☐ CODEINE
- ☐ ERYTHROMYCIN
- ☐ PENICILLINS
- ☐ SULFA DRUGS
- ☐ TETRACYCLINE
- ☐ XANTHINES (ex: THEOPHYLLINE)

HEALTH CONDITIONS

- ☐ ANGINA
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLOOD CLOTTING
- ☐ HIGH BLOOD PRESSURE
- ☐ BREAST FEEDING
- ☐ CANCER
- ☐ DIABETES
- ☐ HEART CONDITIONS
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ PARKINSON'S DISEASE
- ☐ PREGNANCY
- ☐ THYROID
- ☐ ULCERS

OTHER ALLERGIES OR KNOWN DRUG REACTIONS

OTHER HEALTH CONDITIONS

PLEASE LIST ANY PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING: (NOT PURCHASED AT THIS STORE)

PLEASE LIST ANY NON-PRESCRIPTION/OTC MEDICATIONS YOU ARE CURRENTLY TAKING:

PATIENT SIGNATURE

THE PHARMACY HAS REQUESTED THE ABOVE INFORMATION FOR THERE RECORDS. THE ABOVE INFORMATION WILL BE KEPT CONFIDENTIAL. YOU AUTHORIZE THE PHARMACY TO BILL YOUR INSURANCE AND PAYMENT INFORMATION LISTED ABOVE FOR GOODS AND SERVICES RECEIVED FROM THE PHARMACY. SINCE HEALTH INFORMATION MAY CHANGE PERIODICALLY, PLEASE NOTIFY US OF ANY CHANGES IN MEDICATION YOU TAKE (PRESCRIPTION AND NON-PRESCRIPTION), ALLERGIES, DRUG REACTIONS, AND/OR HEATH CONDITIONS.

PATIENT SIGNATURE_____ **DATE**_____

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Woodstock Health Mart Pharmacy
8612 Main Street
Woodstock, GA 30188
Phone – (770) 926-6478 ~ Fax – (770) 591-7557

I _____, authorize Woodstock Pharmacy to repackage my medications in accordance with the Rules and Regulations of the State of Georgia, Rule 480-9-.04 Redispensing by Different Pharmacy.

Patient Signature: _____ Date: _____

Or

Caregiver Signature: _____ Date: _____