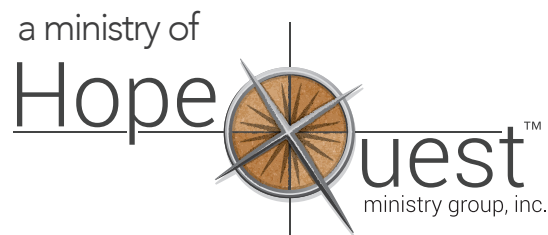




A RESIDENTIAL TREATMENT PROGRAM FOR MEN

Client Application

Experience Freedom • Discover Hope



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

Email: emily.woodfin@hopequestgroup.org

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

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 <input type="radio"/> SELF	
Name	Date of Birth
Address	

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



HOPEQUEST PATIENT INFORMATION

PATIENT INFORMATION									
LAST NAME					FIRST NAME			M.I.	
DATE OF BIRTH				LAST 4 SSN			GENDER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ADDRESS							APT #		
CITY					STATE			ZIP	
HOME PHONE					CELL PHONE				
INSURANCE									
DO YOU HAVE ANY PRESCRIPTION INSURANCE?				<input type="checkbox"/> PRIVATE		<input type="checkbox"/> MEDICARE		<input type="checkbox"/> MEDICAID <input type="checkbox"/> 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	<input type="checkbox"/> VISA <input type="checkbox"/> MASTER CARD <input type="checkbox"/> AMERICAN EXPRESS <input type="checkbox"/> DISCOVER								
NAME ON CARD							BILLING ZIP		
CARD NUMBER					EXP DATE			CVV2	
MEDICAL INFORMATION									
KNOWN ALLERGIES & DRUG REACTIONS					HEALTH CONDITIONS				
<input type="checkbox"/> NO KNOWN ALLERGIES/DRUG REACTIONS					<input type="checkbox"/> ANGINA		<input type="checkbox"/> HEART CONDITIONS		
<input type="checkbox"/> ASPIRIN					<input type="checkbox"/> ANEMIA		<input type="checkbox"/> KIDNEY DISEASE		
<input type="checkbox"/> CEPHALOSPORINS (ex: KEFLEX, CECLOR)					<input type="checkbox"/> ARTHRITIS		<input type="checkbox"/> LIVER DISEASE		
<input type="checkbox"/> CODEINE					<input type="checkbox"/> ASTHMA		<input type="checkbox"/> LUNG DISEASE		
<input type="checkbox"/> ERYTHROMYCIN					<input type="checkbox"/> BLOOD CLOTTING		<input type="checkbox"/> PARKINSON'S DISEASE		
<input type="checkbox"/> PENICILLINS					<input type="checkbox"/> HIGH BLOOD PRESSURE		<input type="checkbox"/> PREGNANCY		
<input type="checkbox"/> SULFA DRUGS					<input type="checkbox"/> BREAST FEEDING		<input type="checkbox"/> THYROID		
<input type="checkbox"/> TETRACYCLINE					<input type="checkbox"/> CANCER		<input type="checkbox"/> ULCERS		
<input type="checkbox"/> XANTHINES (ex: THEOPHYLLINE)					<input type="checkbox"/> DIABETES				
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 _____		



HealthMart.
PHARMACY

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: _____

Your locally owned, independent pharmacy.