**ATASCOSA HEALTH CENTER, INC.**
**Doing Business As**

**BLACK / BLUE INK ONLY**

 Atascosa Health Center  Karnes Community Health Center  Lytle Community Health Center
 Live Oak Community Health Center  McMullen Community Health Center  Wilson Community Health Center
 Poteet Community Health Center

# Patient Registration Form

**Patient Information:**

Patient Name:________________________________ SS#:__________________ DOB:______________ Sex:____

Gender Identity: Female; Female-to-Male; Male; Male-to-Female; Neither Male/Female; Choose not to disclose

Sexual Orientation: Straight (not lesbian or gay); Bisexual; Lesbian/Gay; Something else; Choose not to disclose

Mailing Address:________________________________ City:______________ State:______ ZipCode:__________

PhysicalAddress:________________________________ City:______________ State:______ ZipCode:_________

Home Phone:_______________ Cell Phone:______________ Marital Status:_____ Preferred Language:__________

Email Address: _________________________________________ Veteran: **Yes/No**

Who is your Primary Care Provider?:__________________ Primary Dental Provider:__________________

**(Please Circle One)**

**Homeless Status:** Doubling Up /Not Homeless/Permanent Housing /Shelter /Transitional /Unknown

**Migrant Worker Status:** Migrant /Not a Farmworker /Seasonal

**Public housing Pri Care:** High Rise /Low Rise / No / Other /Section 8

**Race:** White /Black /Asian /American Indian or Alaska Native/Other Race **Ethnicity:** Latino / Hispanic **Yes/No**

**How did you hear about services offered at Atascosa Health Center, Inc.?**

1. Yellow Pages/Other Directory _____
2. Friend/Family _____
3. Event/Health Fair _____
4. Radio/Website _____

**Insurance Subscriber:**

Subscriber Name:______________________________ DOB:__________________ SS#:______________________

**Parent/Legal Guardian Information: (Applicable only if different from above)**

Relationship:____________ Full Name:_________________________ DOB:_____________ SS#:________________

Mailing Address:_______________________________________ City:______________ State:_____ Zip Code:______

Phone Number:___________________ Cell Phone:____________________ Alternate Number:__________________

**Preferred PHARMACY:**

Pharmacy Name: _____________________________City: _______________Zip: _________Phone:_______________

**Acknowledgment of Privacy Notice:**

I acknowledge that **I have received** the Notice of Privacy Practices and its purpose and content have been explained to me.

I certify that the above information is true and correct, if any information is falsified, I will be responsible for payment of services.

__________________________________________________ __________________
**Signature of Responsible Party/Parent/Legal Guardian** **Date**

__________________________________________ __________________
Verifying Employee Date

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## Sliding Scale Fee Screening Worksheet

Patient Name:____________________________________________________________ DOB:________________

I understand that the Health Center will determine eligibility based on the information I have provided. I further understand that if I am found to have given inaccurate information, it will be grounds for the Center to exclude me from any discounted charges.

***Please initial ONE option below:***

1. _____ I certify that **I am providing written proof** of the income that my **Household** receives at this time.
2. _____ I understand that **I am responsible for the total charges** without discounts **until I bring written proof within 5 business days which verifies household and income.** Documents may include such items as current regular payroll stub and or income tax return.
3. _____ I hereby certify that **I am declining the opportunity to apply for the sliding scale discount program**. I understand that I may inquire and apply for the sliding scale discount fee at a later time.

| | Name House Hold Members | Relationship |
|---|---|---|
| 1. | | Self |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

***(CSR use only) Please show your income calculations below***

Office Use Only
Total Family Member: ____________ Total Income: ___________ Sliding Fee Scale%: ________________

Verifying Employee: __________________________________________Date:______________________________

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# HIPAA and Advance Directive

Patient Name: ___________________________________________ DOB: _____________

**Advance Directive:**

_____ Yes _____No 1. Do you have an "Advance Directive"?

_____ Yes _____No 2. If No, do you wish to have information regarding an: Advance Directive"?

**HIPAA Communication Authorization:**

1. The physician/practice/mid-level provider may use or disclose the following protected health information:
_____ All Test Results _____ The Entire Medical Record _____ Todays Chart Note
2. The following protected health information is specifically excepted from disclosure:
_____ Behavioral Health _____ Nothing
3. The purpose of the disclosure is:
_____ Continued Medical Care _____ Employers Use _____ School Use

There are occasions when family members, friends or others may be involved in yours or your child's care. As the patient, parent/ legal guardian, you will want our staff to be able to communicate directly with them. In order to protect the privacy of yours or your child's personal health information, please share with us the names of those individuals with whom we can discuss yours or your child's care and share the protected health information.

Please list below those authorized individuals:

| **Name** | **D.O.B** | **Relationship** |
|---|---|---|
| 1.______ | | |
| 2.______ | | |
| 3.______ | | |

**Closest Relative Not At Same Address in case of Emergency *(EMERGENCY CONTACT):***

Relationship: ____________ Full Name:________________________

Phone Number:___________________ Cell Phone:____________________ Alternate Number:__________________

In addition, please indicate how the **Atascosa Health Center Inc.,** may contact you:

_____Home Telephone _____Cell Phone _____Mail

May we leave a message on you cell phone/ answering machine? _____Yes _____No

I have completed this form to the best of my knowledge:

______________________________________ ____________________________

**Signature of Patient, Parent or Legal Guardian** **Date**

______________________________________ ____________________________

Verifying Employee Date

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# Consent for Treatment of an Adult

Name of Patient: ___________________________ Date of Birth: ____/____/____

**Name of person giving consent if different from Patient: [Print Name]:** ____________________________________

**Relationship to Patient:** □ Self □ Parent □ Guardian □ Other: _______________

I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services to me at the center's service locations. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent, or until the center changes its services and asks me to complete a new consent form.

My signature on this form indicates that: I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.; I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.; I understand that midlevel providers (Physician Assistants and Advanced Practice Registered Nurses) may be involved in my treatment and I consent thereto.; I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require such.; I hereby voluntarily give my consent to Treatment at the Center.

______________________________________________________________________

**[Signature of Patient/Legal Representative]**

Print Name: ______________________________ Date/Time: ________________

If signed by other than Patient, indicate relationship: ___________________

______________________________________________________________________

[Signature of Witness]

Print Name of Witness: _________________________________ Date/Time: _______________

**Interpreter/Translator to complete when applicable:**

I have accurately and completely read/translated the foregoing document to: _____________________________ in
Patients or patient's legal representatives name
_______________ Spanish________ Other Language: __________________________, the Patients or Patients Legal Representative's primary language. She / He understood all of the terms and conditions and acknowledged his/her agreement and consent there to by signing the document in my presence.

**Interpreted/Translated By Signature: ___________________________**

Print Name of Interpreter/Translator: _____________________________ Date/Time: _____________________________

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## PATIENT RIGHTS AND RESPONSIBILITIES

Patient Name: ___________________________________________ DOB: ______________

Welcome to your community health center. Our goal is to provide health care to qualified persons in this community based on a sliding fee schedule. As a patient, you have rights and responsibilities. The Center and staff also has rights and responsibilities. We want you to understand these rights and responsibilities. Please read this statement and ask questions, if you have any.

### A. Human Rights

You have the right to be provided services in a timely manner and be treated with respect and dignity regardless of race, age, religion, sex, handicap, color, or national origin (including limited English proficiency). The Center staff has a right to be treated with respect and dignity. A "Non-Discrimination" statement is posted for public viewing as is other information as required by HHSC Civil Rights Office including language assistance services are available free of charge and you are not obligated to provide your own interpreter or translator.

### B. Payment for Services

1. You are responsible for giving us accurate information about your present financial status and any changes in your financial status. We require this information to determine charges or to bill private insurances, Medicaid, Medicare or other benefits you may be eligible for. If your income is less than the federal poverty guidelines, you will be charged a small fee. Depending on your income, you may be eligible to receive other services.
2. You have a right to receive an explanation of your bill. Charges are due immediately after services are received. Other payment arrangements are available.
3. Federal law prohibits us from denying services, which are medically necessary, solely because you cannot pay for those services.

### C. Privacy

You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private. Only legally authorized persons will review your records unless you give us written permission to provide information about your treatment to someone else. A complete discussion of your privacy rights known as "Notice of Client Privacy Rights" is being provided to you. The Notice details the various rights granted to you by the Health Insurance Portability and Accountability Act.

### D. Health Care

1. You are responsible for providing us accurate, complete and current information about your health so that we can give you proper health care. You have a right and are encouraged to participate in decisions about your treatment.
2. You have a right to information and explanations in the language you normally speak and in words that you understand. You have a right to information about your health or illness, treatment plan, including the nature of your treatment; its expected benefits; if inherent risks and hazards (and the consequences of refusing treatment): the reasonable alternatives, if any (and their risks and benefits); and the expected outcome, if known. This information is called obtaining your informed consent.
3. You have the right to receive information regarding "Advanced Directives." If you do not wish to receive this information, or if it not medically advisable to share that information with you, we will provide it to your legally authorized representative.
4. You are responsible for appropriate use of our services, which includes following our staff instructions, making and keeping scheduled appointments, and only requesting a "walk in" appointment when you are ill. We may not be able to see you unless you have an appointment. If you cannot follow the staff's instructions, please tell us so we can help you.
5. If you are an adult, you have a right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of your refusing

such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed." You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in your best interest, you may be asked to sign a Refusal to Permit Medical Treatment or Services Form or Against Medical Advice Form (as appropriate).

6. You have a right to health care and treatment that is reasonable for your condition and within our capability, however, the center is not an emergency care facility. You have a right to be transferred or referred to another facility for services that we cannot provide. But, we do not pay for services that you receive from another healthcare provider.
7. If you are in pain, you have a right to receive an appropriate assessment and management, as necessary.

**E. Center Rules**

1. You have a right to receive information on the health services we provide, personal conduct, rules, and the use of our property and resources. You are responsible for obeying these rules. If you have any questions, please ask us.
2. You are responsible for the supervision of children you bring with you to the Center. You are responsible for their safety and the protection of other patients and our property.
3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments you may be subject to meet with the CEO or designee to determine whether you can continue services at the center.

**F. Complaints**

1. If you are not satisfied with our services, please tell us. We welcome your suggestions so we can improve our services. As an Atascosa Health Center Inc., patient, you have the right to file a grievance and be involved in the resolution of conflicts concerning care decisions. We will tell you how to file a complaint. In case of questions concerning complaints or desire to file a complaint please contact Chief Operations Officer.
2. If you make a complaint, no center representative will punish, discriminate or retaliate against you for filing a complaint, ant the center will continue to provide you services. As a Health Care Organization, we have posted information on how to file a complaint with the Texas Department of State Health Services and/or with the Joint Commission. If you have questions on how to file a complaint, please ask one of our staff members.

**G. Termination**

If we decide that we must stop treating you as a patient, you have a right to advance notice that explains the reason for the decision and you will be given 30 days to find other health care services. However, we can decide to stop treating you immediately and without notice if you have created a threat to the safety of the staff and/or other clients. You have a right to receive a copy of the Center's termination of the Patient and Center Relationship policy.

**Reasons for which we may stop seeing you include:**

1. Failure to obey center rules and policies, such as keeping scheduled appointments;
2. Intentional failure to report accurate information concerning your health or illness;
3. Intentional failure to follow your health care program, such instructions about taking medications personal health practices, or follow-up appointments, as recommended by your provider.
4. Creating a threat to the safety of the staff and/or patients.

**H. Appeals**

If we make the decision to terminate you as a patient, you have the right to appeal our decision to the Board of Directors. While you are appealing our decision we will not see you as a patient, unless you experience an emergency.

**I have read, understand, and agree to follow the above.**

_______________________________________________ _______________
**Signature of Patient, Guardian or Legal Representative** **Date**

_______________________________________________ _______________
Signature of Employee Date

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## Medicaid Client Acknowledgment Consent – REQUIRED MONTHLY

I, ______________________________ the ________________________ of ____________________________
**(Name of Person Giving Consent)** **(Relationship to Patient)** **(Patient Name)**

understand that, in the opinion of Atascosa Health Center, Inc. the services or items that I have requested to be provided to me on ____________________ may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

I understand that this consent will remain in effect for a **full month and renewed on a monthly basis.**

______________________________________________ ________________________________
**Signature of Patient or Authorized Person** **Date**

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## PRIVATE Insurance Benefits Consent - REQUIRED ANNUALLY

I, ______________________________ the ________________________ of ____________________________
**(Name of Person Giving Consent)** **(Relationship to Patient)** **(Patient Name)**

hereby authorize Atascosa Health Center, Inc.to furnish information carriers or third party liability concerning my illness and treatment with respect of services rendered. I agree that I am responsible for all charges incurred. I assign all payments for services rendered to Atascosa Health Center, Inc. I understand that I am financially responsible for all charges whether or not covered by insurance.

I understand that this consent will remain in effect for a **full calendar year and renewed on an annual basis.**

______________________________________________ ________________________________
**Signature of Patient or Authorized Person** **Date**