HOPE FAMILY HEALTH CENTER
REGISTRATION FORM
(Please Print)

Today's date:	Date of First Appointment (office Only)

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Social Security no.:	Home phone no: Email:			
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.:			

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

Have you ever been a patient of HOPE? ❑ Yes ❑ No (If yes, last date seen) _____

Are you a patient of any other clinic besides HOPE? ❑ Yes ❑ No (If yes, where) _____

HOUSEHOLD INFORMATION/MEDICAL COVERAGE INFORMATION

Are you insured ❑ Yes ❑ No		Do you have Medicaid/Medicare or Hidalgo County Indigent? ❑ Yes ❑ No	
		Annual Household Income:	
		Number of persons in household:	

Sources of household income: ❑ Unemployment ❑ TANIF ❑ Social Security

HOPE SERVICES

What services would you like to receive? ❑Medical ❑ Counseling

IDENTIFYING INFORMATION – MUST BE PROVIDED PRIOR TO SEEING PHYSICIAN/THERAPIST

Please Provide the following:	**Proof of Identification** (State ID /License; Birth Certificate, School ID, or Election Card)
	Income Verification (W2, 3 pay stubs, Unemployment Benefits, etc)
	Proof of Residency (proof of address on bill, receipt, etc)

PROCESS OF ENROLLMENT/HOPE POLICY

Once this form is received by HOPE and information is entered into our system patients are called for appointment.
Medical providers are volunteers and appointments are based on their availability.
We do not accept walk ins for counseling or for medical.

Additional medical information forms will be completed at the first time of visit.

HOPE is a medical home and it is HOPE's policy to have patients' medical and counseling needs met at one clinic.
Patients are asked to bring all medical records to initial visit as well as medication to every visit with the physician.
Patients are asked to leave a donation for HOPE services at each time of their visit (preferably $5-$10).
HOPE is not responsible for the payment of medical procedures/referrals

Referrals for all procedures outside of HOPE Clinic are the financial responsibility of patients.

The above information is true to the best of my knowledge. I u. I understand that I am financially responsible for any procedures outside of HOPE volunteer's donated medical and counseling care

Patient/Guardian signature *Date*

Patient's Rights and Responsibilities

Patient Name:_____ **Date Of Birth:**_____

Please initial the form provided to you indicating that you have read through and understood the below information.

____ I understand that I am responsible for all lab payments prior to them being done.

____I understand that I am responsible for a donation fee.

____ I understand an individual or family receiving counseling services will be asked for one donation each month.

____ I understand that the donation rate will change to a sliding scale in 2019.

____I understand that I have to update my income information every 6-8 months.

____I understand HOPE may refer me to a specialist outside of the clinic and if I need assistance with this referral I must speak to a Care Coordinator/Case Manager.

____I understand HOPE will not pay for any referrals not provided by HOPE, signed by HOPE, or approved by HOPE.

____I understand if my specialist or third party refers me to another doctor or for additional testing/lab work I am responsible for that payment and I will not ask HOPE to pay for the expenses not approved by HOPE staff.

____I understand that once I am referred I am responsible for keeping my appointments.

____I understand that not keeping my appointments may void any future appointments or assistance by the organization.

____I understand I will be responsible for updating any contact information in the future.

____I understand my case will be closed if I miss or cancel **THREE** appointments.

____I understand that the physicians of HOPE are volunteers.

____I understand that HOPE providers may discuss my health with each other with my best interest in mind.

Patient Signature: _____ **Date:** _____

IF MINOR, Legal Guardian's Printed Name: _____

Guardian's Signature: _____ **Date:** _____

Non-Discrimination Clause: No person will be discriminated against because of age, race, color, religion, gender, sexual orientation, disability or national origin.

Revised 5/7/19

HOPE FAMILY HEALTH CENTER
Counseling Services
CONSENT TO TREATMENT

This form is to document that I, _____, have given my permission and consent to the clinical personnel/volunteers/interns to provide psychotherapeutic treatment to me and/or _____who is/are my spouse/child/children.

Outcomes: While I expect benefits from this treatment, I fully understand that because of factors beyond our control, such benefits and particular outcomes cannot be guaranteed.

Response to treatment: I understand that because of the counseling or therapy, I/he/she/we may experience emotional strains, feel worse during treatment, and make life changes; which could be distressing.

Emergency services: I understand that this therapist is ***Not*** providing an emergency service, and I have been informed of whom to call upon in an emergency during the weekend and evening hours.

Attendance: I understand that regular attendance will produce the maximum benefits, but that I or we am/are free to discontinue treatment at any time. If I decide to do so, I will notify the therapists at least two weeks in advance so that effective planning for continued care can be implemented.

Client privacy, confidentiality and release of information: I understand that conversations with the therapist will almost always be confidential. I further understand that the therapist, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the therapist has legal responsibility to protect anyone I/he/she/we may threaten, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the therapist will make reasonable efforts to resolve these situations before breaking confidentiality.

Consultation: I understand that the therapist attends weekly staffing meeting in which certain cases are discussed among other clinic therapists for the purpose of consultation.

Litigation: I agree that I will not involve the therapist in any current or future litigation within the court system. Should your therapist be subpoenaed or requested to appear or testify in court on your behalf, the hourly fee will be $250.00 per hour with a four hour minimum per day.

Public acknowledgement: Therapists are obligated to maintain appropriate boundaries with current and past clients. Friendships, sexual relations or any sexual contact between a therapist and a client or former client are inappropriate. To respect confidentiality, privacy and safety between the therapist and client the therapist will ***Not*** acknowledge a client in public settings.

Use of Technology: I understand that the use of technology (text message, e-mail) may be used to remind clients of their appointments as well as to communicate. I understand my therapist will take necessary measures to enhance protection of private information and maintain clear boundaries. I fully understand the risks and benefits involved with the use of technology. I understand the use of

technology may be used to conduct an electronic search for the purpose of protecting the client or other people from serious, foreseeable, and imminent harm or for other compelling professional reasons.

Gifts: I understand therapist ***cannot*** accept gifts or services from clients for professional services.

I understand that I am financially responsible for this treatment and for the fees.

I know of no reasons I/he/she/we would not undertake this therapy and I/he/she/we agree to participate fully and voluntarily.

Signature: _____ Date: _____
(Patient or a person authorized to consent for patient)

Relationship to client:_____

Witness signature:_____ Date:_____

Non Discrimination Clause: No person will be discriminated against because of age, race, color, religion, gender, sexual orientation, disability or national origin.

Revised 1/10/19

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*EMERGENGY CONTACT INFORMATION/ INFORMACION PARA EMERGENCIAS

Please name an individual whom HOPE can contact in the case of an Emergency regarding your health services. Please note this individual can be changed.

NAME _____ HOME PHONE: _____

ADDRESS_____WORK PHONE: _____

CITY_____ ST._____ZIP_____

RELATIONSHIP TO YOU_____

*In case of an emergency this person will be called and will be notified.

_____Initials: I do not wish to list an emergency contact individual.

MEDICATION AGREEMENT

Patients of HOPE Family Health Center must bring ALL MEDICATION to each visit with their medical provider. Patients must have a list of accurate me dosage, and how many times taken daily or must be able to explain this to the Medical Assistant and provider.

If a patient does not bring all medication to their appointment they will not be seen and they will be rescheduled for the next available appointment.

Signature below is acknowledgment of this policy at Hope. By signing this document, patient agrees to bring in proper documentation/medications to all visits.

Medication dispensed as samples have been donated by a reliable medical source. These medications may/may not be within their date of expiration. The Signature below is acknowledging the fact that not all medication given as samples are within expiration date but have been approved by the Medical Director of HOPE Family Health Center.

I understand that by signing this agreement I am aware I must bring all medication to my appointments and if I do not I will be rescheduled.

Patient Signature_____Date:_____

Department of State Health Services Notice of Privacy Practices

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective September 1, 2017), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative (Print) Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please be specific):

_____

_____

_____ _____

Employee Signature Date

Notice of Electronic Disclosure of Protected Health Information

If the Department of State Health Services (DSHS) obtains or creates information about your health, DSHS is required by law to protect the privacy of your information. Protected health information (PHI) includes any information that relates to:

- Your past, present, or future physical or mental health or condition;
- Health care provided to you; and,
- Past, present, or future payment for your health care.

DSHS may not disclose your PHI electronically without your authorization unless allowed by law. For example, DSHS may share your PHI through approved, secure electronic methods for the purpose of treatment, payment for health care services, or health care operations such as case management or care coordination. DSHS may also need to share your PHI electronically for public health purposes such as preventing and controlling the spread of infectious diseases or for certain disaster relief efforts. For a complete list of reasons that DSHS is allowed by law to share your PHI, please refer to the DSHS Privacy Notice www.dshs.state.tx.us/hipaa/privacynotices.shtm.

If you believe that DSHS has violated the obligations described in this notice, you have the right to file a complaint with the DSHS Privacy Officer by mail at Mail Code 1915 P.O. Box 149347, Austin, TX 78714-9347; or by telephone at 512-776-7111; or by e-mail at: hipaa.privacy@dshs.state.tx.us.

HOPE FAMILY HEALTH CENTER 2019 SLIDING DONATION FEE SCALE
Based on the Federal Poverty Tax Guideline

Family Size	Income Measures	Category A Up to 100% $5 Donation Per Visit	Category B 100.01%-174.99% $10 Donation Per Visit	Category C 175% + $15 Donation Per Visit
1	Annual	$0-$12,140	$12,141-21,244	$21,245+
	Monthly	$0-$1,012	$1,013-$1,771	$1,772+
2	Annual	$0-$22,600	$22,601-$36,200	36201+
	Monthly	$0-$1,883.33	$1883.34-$3,016.67	$3,016.68+
3	Annual	$0-$24,450	$24,451 - $40,700	$40,701+
	Monthly	$0-$2,037.50	$2,037.51-$3,391.66	$3,391.67+
4	Annual	$0-28,250	$28,251-$45,200	45201+
	Monthly	$0-$2,354.17	$2,354.18-$3,766.67	$3,766.68+
5	Annual	$0-$30,550	$30,551-$48,850	$48,850+
	Monthly	$0-$2,545.83	$2,545.84-$4,070.83	$4,070.84+
6	Annual	$0-$32,800	$32,801-$52,450	$52,451+
	Monthly	$0-$2,733	$2,734-$4,370.83	$4,370.84+
7	Annual	$0-$35,050	$35,051-$56,050	$56,051+
	Monthly	$0-$2,920.83	$2,920.84+$4,670.83	$4,670.84+
8	Annual	$0-$37,301	$37,301-$59,700	$59,701+
	Monthly	$0-$3,108.36	$3,108.37-$4,975	$4,976+

Exclusions

- **Lab Cost**
- Some in office procedures
- Injections
- No offsite services such as hospital fees, x-rays, or diagnostic testing are eligible.

NOTE: Patients of HOPE Family Health Center are responsible for the cost of diagnostic testing, lab work, or procedures from third party companies, physician offices, or hospitals. The above chart does not apply to groups, which is a separate donation.

All patients of HOPE Family Health Center must participate in a meeting where their sliding donation fee scale will be assessed.

NAME: _____ DOB: _____ Family Size: _____

The following is required:

- Proof of income (W2, two consecutive pay stubs for all adults in home, a signed letter indicating payments received (if cash))
- Proof of address and Photo ID

Name/DOB of all persons living in house hold of all living in household:

_____ _____

_____ _____

_____ _____

_____

Patient Signature

For HOPE STAFF: Date of Eligibility meeting: _____

_____ Income Verification: _____ W2 _____ Paystub _____ letter _____ Proof of Address

$_____ Total Household Income

_____ Persons residing in Home

Sliding Scale Category

____ A ($5) ____ B ($10) ____ C ($15)

_____ _____

Verified By Date

Other:

___Precinct 2 ____ Precinct 3 ____ McAllen

___ Hidalgo County Indigent __ Homeless

_____

___ IBH ____ Med ____ Counseling __ DSRIP

Group Recommendation: ___NA or

_____

_____

Other:

Personal Health Action Plan

Name: _____
Date: _____
Phone: _____

The change I want to make happen is:

_____
_____
_____.

My goal for the next visit:

_____
_____
_____.

Action Plan

The specific steps I will take to achieve my goal/s are (include what, when, how, where, and how often)

_____
_____
_____.

The things that could make it difficult to achieve my goal/s include....My plan to overcome these challenges include:

_____
_____
_____.

Support and resources I will need to achieve my goal/s include:

_____
_____
_____.

My confidence that I can achieve my goal/s is (scale of 0 to 10 with zero being not confident at all and 10 being extremely confident). _____

Date Reviewed: _____

Person that plan was reviewed with: _____