



HOPE FAMILY HEALTH CENTER REGISTRATION FORM

(Please Print)

Pt. I.D. _____

Today's Date:		Date of First Appointment (office Only)				
PATIENT INFORMATION						
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms. <input type="checkbox"/> They/Them	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth Date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> NB
Street address:		Social Security Number: (Optional)		Phone Number:		Email:
P.O. Box:		City:		State:	ZIP Code:	
Occupation:		Employer:		Employer Phone Number:		
Chose clinic because/Referred to clinic by (please check one box):						<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Social Media	<input type="checkbox"/> Other	<input type="checkbox"/> Dr.	
Other family members seen here:						
Have you ever been a patient of HOPE? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, last date seen) _____						
Are you a patient of any other clinic besides HOPE? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, where) _____						
HOUSEHOLD INFORMATION/MEDICAL COVERAGE INFORMATION						
Are you insured?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have Medicaid/Medicare or Hidalgo County Indigent?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Annual Household Income:				
		Number of persons in household:				
Sources of household income: <input type="checkbox"/> Unemployment <input type="checkbox"/> TANF <input type="checkbox"/> Social Security						
HOPE SERVICES						
What services would you like to receive?				<input type="checkbox"/> Medical	<input type="checkbox"/> 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, Passport or Election Card)				
		Income Verification (Income Tax Return, W2, 3 Months of Pay Stubs, Unemployment Benefits, SNAP Benefits, etc.)				
		Proof of Address: Water or Light Bill Receipt, etc.				
		Social Security Card (if applicable)				
PROCESS OF ENROLLMENT/HOPE POLICY						
<p>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 services.</p> <p>Additional medical information forms will be completed at the first time of visit.</p> <p>HOPE is a medical home and it is HOPE's policy to have patient's 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-\$15). HOPE is not responsible for the payment of medical procedures, medications and/or referrals</p> <p><u>Referrals for all procedures outside of HOPE Clinic are the financial responsibility of patients.</u></p>						
<i>The above information is true to the best of my knowledge. I understand that I am financially responsible for any procedures outside of HOPE volunteer's donated medical and counseling care.</i>						
_____ Patient/Guardian Signature				_____ Date		



EMERGENCY CONTACT INFORMATION

Please name a person HOPE can contact in the event of an emergency related to your health services. Please note that this person can be changed.

NAME: _____ PHONE: _____

ADDRESS: _____ WORK PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

RELATIONSHIP WITH YOU: _____

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

I do not want to include an emergency contact. Initials: _____

MEDICATION AGREEMENT

Hope Family Health Center patients must bring ALL MEDICATIONS to each visit with their medical provider. Patients should have a list of precise dosages and how many times they are taken per day or they should be able to explain this to the physician assistant and provider.

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

The signature below is an acknowledgment of this policy at Hope Family Health Center. By signing this document, the patient agrees to bring proper documentation / medications to all visits.

Medications dispensed as samples have been donated by a trusted medical source. These medications may or may not be within their expiration date. The signature below acknowledges the fact that not all medications provided as samples are within the expiration date, but have been approved by the Hope Family Health Center Medical Director.

I understand that by signing this agreement, I am aware that I must bring all medications to my appointments. And if I don't, my appointment will be rescheduled.

Patient 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.



February 25, 2020

RE: Walk in Encounters

To all patients of HOPE:

It is the policy of HOPE Family Health Center to see **only the first 8 walk in patients per day if providers are available.**

If the eight (8) slots have been filled for the day, no other walk ins will be taken and an appointment will be made for the patients.

HOPE will only see current patients as walk ins. A recommended donation of \$5-\$15 will be requested for walk in appointments.

If a patient has an emergency, they are encouraged to call 9-1-1 or go to the Emergency Room. **HOPE is not an emergency clinic.**

If a walk in slot is not available, the front office staff will schedule an appointment with the patient. If a patient already has an upcoming appointment, they are encouraged to keep their appointment and not use one of the limited walk in slots.

HOPE providers are volunteers. In the case that HOPE does not have a volunteer at the clinic, no walk ins will be accepted.

Sincerely,

Administration – Roxanne Pacheco, LCSW-S, CCTP, CMHIMP, CLYL

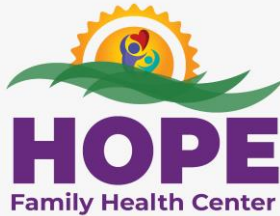
Interim Executive Director

Patient Acknowledgement

- *I understand the walk in rules of Hope Family Health Center.*
- *I understand HOPE will only see the first 8 walk ins.*
- *I understand that if the 8 slots are filled, I will not be seen as a walk in that day. The front office will schedule my appointment.*
- *I understand HOPE is not an emergency facility*
- *I understand HOPE medical providers are volunteers and a provider may not be available to I see me when I come in as a walk in*
- *I understand I will be asked for a \$5 - \$15 donation for a walk in appointment.*

Patient Signature/Acknowledgement

Date



Hope Family Health Center
2332 Jordan Rd. McAllen, Texas 78503
Tel: 956.994.3319
Fax: 956.971.9377
Website: www.hopefamilyhealthcenter.org

Notice to Patients

HOPE Family Health Center providers are volunteers. HOPE has never had a physician on staff. We utilize the volunteer services of medical doctors, physician's assistants, and the residents from the University of Texas-Rio Grande Valley.

It is because of this structure that we are unable to:

- Sign off on physical disability forms
- We cannot complete or sign narrative forms for disability
- Providers cannot provide statements for disability forms

Please know that we pride ourselves in providing primary and chronic care management to our clients. We are proud to be a home clinic to many of the uninsured and will do all we can on our part to help others achieve their health goals.

Please know that HOPE can only take medical orders from HOPE provider and only can honor the prescriptions from a HOPE provider. We do not accept any outside referrals for procedures or for medication.

Thank you

Roxanne Pacheco, LCSW-S, CCTP, CMHIMP, CLYL

Interim Executive Director

r.pacheco@hfhcenter.org



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.

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 (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.

Printed Name (Print)

Patient Signature

If completed by a patient's 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 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/hippa/privacynotices.shtm.

If you believe that DSHS has violated the obligation 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 hippa.privacy@dshs.state.tx.us

DEPARTMENT OF STATE HEALTH SERVICES NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

When you receive treatment or benefits from an Department of State Health Services (DSHS) facility or program, we receive, create and maintain information about your health, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your health information without your authorization for treatment, payment, and health care operation purposes. Examples include but are not limited to:

- Using or sharing your health information with other health care providers involved in your treatment or with a pharmacy that is filling your prescription.
- Using or sharing your health information with your health plan to obtain payment for services or using your health information to determine your eligibility for government benefits in a health plan.
- Using or sharing your health information to run our business, to evaluate provider performance, to educate health professionals, or for general administrative activities.

We may share your health information with our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.

We may use or share your health information without your authorization as authorized by law for our patient directory, to family or friends involved in your care, or to a disaster relief agency for purposed of notifying your family or friends of your location and status in an emergency situation

We may use and disclose your health information without your authorization to cntact you for that following activities, as permitted by law and agency policy: providing appointment reminders; describing or recommending treatment alternatives; providing information about health-related benefits and services that may be of interest to you; or fundraising.

We may also use and disclose your health information without your authorization for the following purposed:

- For public health activities such as reporting diseases, injuries, births, or deaths to a public health authority authorized to receive this information, or to report medical device issues to the FDA;
- To comply with workers compension laws and similar programs;
- To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if the agency resonably believes you are a victim of abuse, neglect, or domestic violence we will make every effort to obtain your permission, however, in some cases we may be required or authorized to alert the authorities;
- For health oversight activities such as audits, investigations, and inspections of DSHS facilities;
- For research approved by an Institutional Review Board or privacy board; for preparing for research such as writing a research proposal; or for research on decedents information;
- To create or share de-identified or partially de-identified health information (limited data sets);
- For judicial and administrative proceedings such as responding to a subpoena or other lawful order;
- For law enforcement purposes such as identifying or locating a suspect or missing person;
- To coroners, medical examiners, or funeral directors as needed for their jobs;
- To organizations that handle organ, eye, or tissue donation, procurement, or transplantation;
- To avert a serious threat to health or public safety;
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and for other law enforcement custodial situations;
- For incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential; and
- As otherwise required or permitted by local, state, or federal law.

DEPARTMENT OF STATE HEALTH SERVICES NOTICE OF PRIVACY PRACTICES

Additional privacy protections under state or federal law apply to substance abuse information, mental health information, certain disease-related information, or genetic information. We will not use or share these types of information unless expressly authorized by law. We will not use or disclose genetic information for underwriting purposes.

We will always obtain your authorization to use or share your information for marketing purposes, to use or share your psychotherapy notes, if there is payment from a third party, or for any other disclosure not described in this notice or required by law. You have the right to cancel your authorization, except to the extent that we have taken action based on your authorization. You may cancel your authorization by writing to the privacy officer per below.

YOUR PRIVACY RIGHTS

Although your health record is the property of DSHS, you have the right to:

- Inspect and copy your health information, including lab reports, upon written request and subject to some exceptions. We may charge you a reasonable, cost-based fee for providing records as permitted by law.
- Receive confidential communications of your health information, such as requesting that we contact you at a certain address or phone number. You may be required to make the request in writing with a statement or explanation for the request.
- Request amendment of your health information in our records. All requests to amend health information must be made in writing and include a reason for the request.
- Request an accounting (a list) if certain disclosures of your health information that we make without your authorization. You have the right to receive one accounting free of charge in any twelve-month period.
- Request that we restrict how we use and disclose your health information for treatment, payment, and health care operations, or to your family and friends. We are not required to agree to your request, except when you request that we not disclose information to your health plan about services for which you paid with your own money in full.
- Obtain a paper copy of this notice upon request.

You may make any of the above requests in writing to the DSHS privacy officer or your DSHS provider's privacy office. You can reach DSHS at (512) 776-7111 or (888) 776-7318 or by email at hippa.privacy@dshs.texas.gov. To request results of lab tests performed by the DSHS lab, please call (512) 776-7318 or visit <http://www.dshs.state.tx.us/lab/patientresults.aspx>.

OUR DUTIES

We are required to provide you with notice of our legal duties and our privacy practices with respect to your health information. We must maintain the privacy of information that identifies you and notify you in the event your health information is used or disclosed in a manner that compromises the privacy of your health information.

We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make the revised notice effective for all health information that we maintain. We will post revised notices on our public website www.dshs.texas.gov and in waiting room areas. You may request a copy of the revised notice at the time of your next visit.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by contacting: **DSHS Consumer Services and Rights Protection/Ombudsman Office** by mail at Mail Code 2019, P.O. Box 149347 Austin, TX 78714-9347; or by telephone at (512) 206-5760 or (800) 252-8154 (toll free); and **Office for Civil Rights, Region VI, U.S. Department of Health and Human Services**, by mail at 1301 Young St., Suite 1169, Dallas, Texas 75202; or by telephone at (800) 368-1019, (214) 767-0432 (fax), or (800) 537-7697 (TDD).

For complaints about a violation of your right to confidentiality by an alcohol or drug abuse treatment program, contact the United States Attorney's Office for the judicial district in which the violation occurred.

We will not retaliate against you for filing a complaint.



HOPE FAMILY HEALTH CENTER 2019 DONATION SCALE

Based on the "Federal Poverty Tax Guideline"

Family Size	Income Measure	Category A	Category B	Category C
		0%- 100% \$5 de Donation per visit	100.01%-174.99% \$10 de Donation per visit	175% + \$15 de 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: HOPE Family Health Center Patients are responsible for the costs of any diagnostic tests, laboratory tests, and / or procedures performed by a third party company, doctor's offices or hospitals. The table above does not apply to groups, so the donation is different.



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 for all adults in the household (W2, three months of pay stubs, notarized letter indicating payments received (if paid in cash))
- Proof of address and identification

Name and Date of Birth of all persons 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

Otro:

_____Precinct 2 _____Precint 3 _____McAllen

_____Mission _____Hidalgo County Indigent _____Homeless

_____IBH _____Med _____Counseling _____DSRIP

Group Recommendation: _____NA

Other: _____