The Health Center of Helping Hands

102 S First Street, Suite B ● Rockwall, TX 75087 ● P: 972-772-8194 ● F: 972-772-8175

Patient's Legal Name:
Last:____First:__________________________________Initial:________

Street Address: ____City: ____________________ State: ________

Zip: ___________County:______________________ Home phone: #_________________________

Alternate Telephone: #_________________________ ☐ work ☐mobile

Date of Birth: __________________ SSN: _______________________Gender: _______ Age: ______

*Ethnicity: Caucasian______Hispanic______ Latino______ African American_____

Asian/Pacific American _____ Native American______ Other____________________________

How did you hear about us? *This information is collected for United Way Grant purposes only

☐Hospital ______________________ ☐Referring Doctor __________________☐ Other ________________________

Employer-Patient's or Parent's (if child)____

Emergency Contact Name ____________________________________Relationship_____________________________

Emergency Contact Phone # __________________________________

Pharmacy Name:____ Phone #______________________________

Payment is expected at the time of service. If we are a participating provider in your insurance plan, you must present a valid insurance card at the time of service or be responsible for payment in full. If a current ID card is not presented prior to the visit the patient will not be eligible for any benefits of the plan.

Signature of Patient (or Parent/Guardian if child):_______________________ Date:__________

PLEASE COMPLETE IF PATIENT IS A CHILD (UNDER 18 YEARS OLD)

Give information for the PARENT/LEGAL GUARDIAN who is accompanying child to this visit

Name: _________________________________ Relationship to Patient:__________________________________
Address: _______________________________ City_____________________State_______Zip_________
Telephone # home___________________Alternate Telephone: #_________________________ ☐ work ☐ mobile

I warrant that I am the party responsible for making medical decisions for the child represented in this medical record. I hereby give my consent to the rendering of both emergency and non-emergency healthcare services by Physician/Nurse Practioner both in and out of my physical presence, and the performance of all necessary diagnostic tests. I acknowledge that payment is due at the time of service, unless other arrangements have been made. I assume financial responsibility for any and all healthcare services provided to this patient. I understand that The Health Center of Helping Hands will not get involved in matters involving third party personal billing whether result of custody, court order or personal circumstances. The parent/guardian accompanying the child to the visit is responsible for any payment due at the time services are rendered.

Signature of Parent/Guardian (as identified above):____

Social Security #: __________________________ DOB: ___________________ Date: ________________________

INSURANCE INFORMATION (Please provide information for the insured/person who provides the coverage)

Primary Insurance Carrier:____

Policy #___________________________________ Group #_________________________

Policyholder Name:__________________________ Policyholder D.O.B.____________________

Policyholder S.S.#___________________________ Policyholder Employer:_________________

Relationship to Patient:_____________________ Is this a PPO/HMO/POS?_________________

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Patient's Legal Name: ____ Date of Birth ____________________________

Consent to Treatment: I hereby give my consent for medical treatment by the physicians/nurse practitioners or under the direction of the physicians/nurse practitioners of the Health Center of Helping Hands (HCHH).

Patient or Guardian Signature ____________________ Date

Payment Policy: I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. The HCHH files claims for Medicare assignment and any of the Managed Care Plans with which we participate. Claims will not be filed with other insurance carriers**.** If you Plan to pay by check and it is dishonored a processing fee of $30 will be assessed.

____________________ Date

Patient or Guardian Signature

Assignment of Benefits: I assign to The Health Center of Helping Hands all payments for medical services rendered to my dependents or myself for services filed to insurance on my behalf.

Patient or Guardian Signature ____________________ Date

Authorization for Release of Medical Information: I hereby authorize The Health Center of Helping Hands to release any medical or incidental information that may be necessary for medical care or to process medical insurance claims for which payment is assigned to the provider.

Patient or Guardian Signature ____________________ Date

I agree to inform providers of all current and past medical history and information: _______ (initial)
I understand that I must keep my appointments and show up in a timely fashion: ________(initial)
I understand that if I am more than 15 minutes late, my appointment may have to be rescheduled: _______(initial)
I understand that I may be dismissed from the Health Center for excessive no shows to my appointments: _____ (initial)

I may revoke consent for any or all of the above initialed items at any time in writing. I certify that all information provided to The Health Center of Helping Hands is correct.

Patient or Guardian Signature ____________________ Date

MEDICARE PATIENT'S ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Health Care Financing Administration (HCFA) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

____

Patient or Guardian Signature Date

I also authorize the same release of information to any Medicare supplemental insurance entities (i.e. Medigap) and further request payment of medical insurance benefits either to myself or to the party who accepts assignment.

____

Patient or Guardian Signature Date

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Patient Agreement & Consent for Treatment by Volunteers

1. I understand that the Health Center of Helping Hands (HCHH) is a non-profit charity organization providing medical care to the uninsured and underinsured.

2. I understand that the personnel working in the clinic are licensed by the State of Texas in their respective fields.

3. I understand that services I receive at the HCHH may be provided by a volunteer who is providing medical care that is not administered for or in expectation of compensation.

4. I further understand that Texas law imposes on the recovery of damages from such volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

    a) the volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization;

    b) the volunteer commits the act or omission in the course of providing health care services to the patient;

    c) the services provided are within the scope of the license of the volunteer; and

    d) before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges:

        1-that the volunteer is providing care that is not administered for or in expectation of compensation; and
        2-the limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

5. I understand that HCHH may refer me to other agencies or other medical providers, subject to my approval if services to meet my needs are not available through HCHH and that I am responsible to the other providers for payment.

6. I understand that some of the providers at the HCHH Clinic are part time and that being seen here by a provider does not entitle me to be seen in another private practice.

7. I understand that HCHH is a smoke free clinic.

8. If I am referred to another provider, I agree that my medical records at HCHH may be copied and sent or faxed to the provider.

9. I understand my records are confidential. I hereby waive confidentiality and authorize HCHH to disclose information necessary for obtaining services for my family or myself.

I have read and understand the above and choose to be treated by a volunteer physician if necessary, understanding the limitations on the recovery of damages described above for:

( ) Myself
( ) The following person I am legally responsible for ____________________________

____

Patient signature (or parent, if minor) Date of Birth Today's Date

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Patient's Name ____Date of Birth____________________

CLIENT PRIVACY NOTICE

I understand that my medical records and financial information are protected information. During the course of my care there will be a need to transmit this protected information for continuing care, for medical referrals, for certain public health activities required by law, for reimbursement for services, for mandated disease reporting, for legal proceedings, for law enforcement activity, and for data collection.

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"), I acknowledge and agree that I have read a copy of the Notice, which will be retained in my medical record.

I understand that the Health Center of Helping Hands (HCHH) may use and disclose necessary personal health information to another party to permit the Clinic to perform its administrative duties, provide me with care and services, process payment information, or share with Rockwall County Helping Hands for assistance purposes. I also understand that the HCHH may need to contact me and transmit information by phone or letter.

I understand that my information is never given to anyone unless there is a need, to which I have agreed.

____
Signature of patient or legal representative Date

I READ OR AN INTERPRETER READ THE HEALTH CENTER OF HELPING HANDS PRIVACY NOTIFICATION POLICY TO ME AND I HAVE HAD MY QUESTIONS ANSWERED AND UNDERSTAND MY RIGHTS TO PRIVACY.

____
Signature Date

____
Witness Date

Patient Preference Regarding Communication of Health Information

We value your privacy, so please indicate your preferences when we are attempting to contact you regarding a specific medical situation. This authorizes HCHH to leave messages for you with detailed information regarding labs and/or prescription instructions. Please initial all that apply below:

Best Contact Number ______________________________

___ OK to leave a message on my HOME PHONE with detailed information

___ OK to leave a message on my CELL PHONE with detailed information

___ OK to leave a message on my WORK PHONE with detailed information

___ OK to mail to my home address

___ OK to leave message with family member:

____

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