The Health Center of Helping Hands

Patient's Legal Name:
Last:____**First:**________________________________**Initital:**______________

Street Address:____**City:**__________________**State:**__________

Zip:__________**County:**____________**Phone:**__________________cell/home/work **Email:**________________________

Date of Birth:_________________________ **Age:**_________ **Gender:** _____**Male** _____**Female** ____**Transgender**

***Ethnicity:** African American_____American Indian_____Asian_____Hispanic____Native Hawaiian/Pacific Islander_____White_____
***Income:** _____Under $24,250 _____$24,251-$35,200 _____$35,201-$56,300 _____Over $56,300
***This information is collected for United Way purposes only**

Patient's Employer/Parent (if under 18):____

Emergency Contact:____**Relationship:**____________________________

Emergency Contact Phone:__________________________

Pharmacy Name:____**Phone:**______________________________

Payment is expected at the time of service, unless other arrangements have been made. 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.

Insurance Information (Please provide information for the insured/person who provides the coverage)

Insurance Carrier:	**Policyholder Name:**
Policy#:	**Group#:**
Policyholder D.O.B.:	**Relationship to Patient:**
Policyholder Employer:	**Is this a PPO/HMO/POS:**
Social Security# (used for referrals):	

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:**___________

Phone:_________________________________ **Home**____ **Cell**_____ **Work**_____

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 Practitioner both in and out of my physical presence, and the performance of all necessary diagnostic tests. I acknowledged that payment is due at the time of service, unless other arrangements have been made. I assume financial responsibility for any and all 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):_________________________**Date:**________

990 Williams Street, Ste A, Rockwall, TX 75087
Phone: 972-772-8194 Fax: 972-772-8175

The Health Center of Helping Hands

Patient's Legal Name:____**Date of Birth**:______________________

Please initial each section and then sign at the bottom.

_____**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.

_____**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 Helping Hands Health Center files for 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. If you confirm appointment and/or fail to attend, a no-show fee of $25 will apply.

_____**Assignments 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.

_____**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.

_____**I agree to inform providers of all current and past medical history and information.**

_____**I understand that I must keep my appointments and show up in a timely fashion.**

_____**I understand that if I am more than 15 minutes late, my appointment may have to be rescheduled.**

_____**I understand that I may be dismissed from the Health Center for excessive no shows to my appointments.**

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.

Signature of Patient (**or Parent/Guardian if child**)**:_____________________________Date:________**

MEDICARE PATIENTS 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.

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.

Signature of Patient:____________________________Date:_____________

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Patient Agreement & Consent for Treatment by Volunteers

1. I understand that the Health Center of Helping Hands 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 Health Center of Helping Hands 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:
      i. That the volunteer is providing care that is not administered for or in expectation of compensation; and
      ii. The limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.
5. I understand that the Health Center of Helping Hands may refer me to other agencies or other medical providers, subject to my approval If services to meet my needs are not available through the Health Center of Helping Hands and that I am responsible to the other providers for payment.
6. I understand that some of the providers at the Health Center of Helping Hands are part-time and that being seen by a provider does not entitle me to be seen in another private practice.
7. I understand that the Health Center of Helping Hands is a smoke free clinic.
8. If I am referred to another provider, I agree that my medical records at the Health Center of Helping Hands may be copied and sent or faxed to the provider.
9. I understand my records are confidential. I hereby waive confidentiality and authorize the Health Center of Helping Hands 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____________________________

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CLIENT PRIVACY NOTICE (HIPAA)

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, 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 Health Center of Helping Hands 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 the Health Center of Helping Hands to leave messages for you with detailed information regarding labs and/or prescription instructions. Please initial all that apply.

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 memberName:__________________________________
Name:__________________________________

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