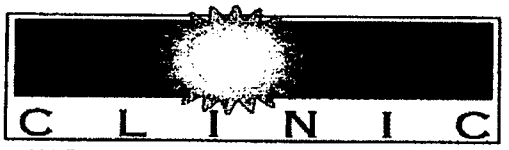


411 East Jefferson St. * Waxahachie, TX 75165

972-923-2440 phone * 972-923-2445 fax

Welcome To Hope Clinic

Please provide the following documentation with your completed Registration Form:

Insured Patients (Medicaid/Medicare/Private Insurance)

- Insurance Card – we need to make a copy of the front and back of your card **every time** you are seen at the clinic
- Photo I.D. or Driver's License

If you would like to apply for a Sliding Fee Discount, please bring the following proof of income with your Photo I.D. or Driver's License:

- We prefer a Tax Return filed in current year, but you can also provide one month of check stubs (if you are paid weekly please bring 4 check stubs, bi-weekly or every other week bring 2 check stubs and monthly bring 1 check stub)
    - If you have undocumented income please ask what documentation you need to bring
- Social Security Income
- Alimony
- Disability Income
- Child Support
- TANF
- Food Stamps (SNAP)

DEPENDENTS ARE ONLY COUNTED IF YOU PROVIDE ONE OF THE FOLLOWING:

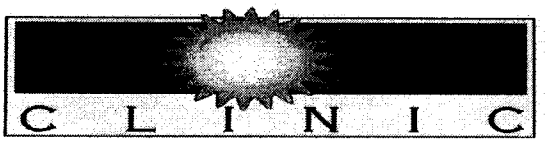
- Tax Return (filed in current year) with dependent listed
- Birth Certificate
- Marriage License
- Adoption Papers
- Proof of Legal Guardianship

*Medical, Dental, Behavioral Health and Labs have separate sliding fee discounts

** The above documentation is required to qualify for the sliding fee discount program

Each patient will be expected to pay for service at the time of the appointment

Fees or co-pays may vary depending on service(s). You may ask the front desk personnel about any expected charges.



PATIENT REGISTRATION

411 E. Jefferson St. Waxahachie, TX 75165 Phone: (972) 923-2440 Fax (972) 923-2445

All information is strictly confidential. (Please Print)

Last Name:	**First Name:**	**MI:**	**Title:**
Street Address:	**City:**		**Zip:**
Generation:	**Gender Identity: [ ] Male [ ] Female [ ] Trans Man [ ] Trans Woman [ ] Genderqueer [ ] Other**		
Sexual Orientation: [ ] Straight [ ] Gay or Lesbian [ ] Bisexual [ ] Other (_____) [ ] Unknown			
Sex: M F	**Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ]**		**Social Security #:**
Date of Birth:	**Home Phone #**	**Work #**	**Cell/Alt #**
Email Address:		**Can we leave a message on your contact # for call back? Yes No**	
Preferred Method of Contact: Email Phone		**Are you able to receive Text Messages? Yes No**	
Patient Race: [ ] White [ ] African American/Black [ ] Asian [ ] Latino [ ] American Indian/Alaska Native [ ] Native Hawaiin [ ] Other Polynesian [ ] More Than One Race			
Patient Ethinicity: [ ] Hispanic [ ] Not Hispanic	**County of Residence**	**Student** FT PT No	**Language(s) Spoken:**
Homeless: [ ] Yes [ ] No	**Veteran:** [ ] Yes [ ] No	**Do you Work in Agriculture?** [ ] Yes [ ] No	**Are you a Migrant or Seasonal Worker?** Migrant Seasonal
Name of Spouse/Parent:	**Spouse/Parent Phone #:**	**Name of person financially responsible for patient:**	**Self [ ] Spouse [ ] Parent [ ]**
Responsible Party's Address Zip Phone Number		**Responsible Party's Birthdate** ___/___/___	**Responsible Party's Social Security #**
Name of Employer:	**Address**	**City**	**Zip Code**	**Phone #**
Reason for Visit:			

INSURANCE

If you are not insured, ask us about our Sliding Fee Discount

Medicare: Yes [ ] No [ ]	**Medicare #**	**Medicaid** Yes [ ] No [ ]	**Medicaid #** **Group Name:**	**Effective Date:**
Medicare Secondary Insurance Name	**Address**		**Policy #**	**Group #**
Primary Insurance Company	**Address**	**Phone #**	**Is insurance through your employer?** Yes [ ] No [ ]	
Subscriber Name	**Subscriber Birth Date** ___/___/___	**Policy #**	**Group #**	
Secondary Insurance Company	**Address**	**Phone #**	**Policy #**	**Group #**

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address): Relationship to Patient:	**Home # Work/Cell #**

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to Ellis County Coalition for Health Options dba Hope Clinic for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient, Parent, or Guardian Signature (if child is under 18 years old) **Date**

C L I N I C

Application for Sliding Fee Scale Discount

411 E. Jefferson St. Waxahachie, TX 75165 Phone: (972) 923-2440 Fax (972) 923-2445

All information is strictly confidential. (Please Print)

As an FQHC, we are able to offer a discounted fee based on your financial ability to pay. To qualify for this Sliding Fee Scale Discount, you must complete this application and provide verification of your household income.

Head of Household Information:

Name: First, Middle Initial, Last):	**Social Security Number:**	**Date of Birth:** ___/___/_____	**County:**
# of Dependents:	**Marital Status:** [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated		

If claiming zero income: Eligibility is only valid for one month. *(Please ask for other options.)*

Income Information: Please complete for all adult household members who are employed

Proof of income is required (Income Tax Return and/or 1 month's paystubs). Otherwise, services will be priced at customary price.

Employed Person/Patient	**Company Name**	**Income (Before Taxes)**	**Paid How Often? (Check One)**
		$	[ ] Weekly [ ] 2 times per month [ ] Monthly [ ] Every 2 weeks
		$	[ ] Weekly [ ] 2 times per month [ ] Monthly [ ] Every 2 weeks
Other Sources of Income:	**Alimony $**	**TANF $**	**Pension/Retirement $**
Child Support $	**Disability $**	**S.S.I $**	**Social Security $**
Unemployment $	**Other $**	**Other $**	**Other $**

Household Information: List ALL individuals in household, including the head of household.

Name	**Date of Birth**	**Relationship**	**Age**	**Employed**	**Income**
1	___/___/_____			Yes / No	
2	___/___/_____			Yes / No	
3	___/___/_____			Yes / No	
4	___/___/_____			Yes / No	
5	___/___/_____			Yes / No	
6	___/___/_____			Yes / No	

By signing below, I agree that the Hope Clinic staff may contact each employer listed and/or other agencies to confirm my income. I will provide Hope Clinic with proof of income for the purpose of calculating my disount. I will be asked to document my income regularly (annually if tax return is provided, monthly if paystubs or insurance is provided). I agree to inform Hope Clinic if there are changes to my income, household size, or insurance coverage. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of services. I hereby certify that the information I have provided is correct.

Applicant Signature _____ Date _____

Guardian or Power of Attorney Signature _____ Date _____

OFFICE USE ONLY

Date Application Received:	**Patient Chart #**	
Employee Initials:	**Sliding Scale : [ ] A [ ] B [ ] C [ ] D [ ] No Income**	
Type of Income Provided:	[ ] Medicaid [ ] Medicare [ ] Private Insurance [ ] Ellis County Indigent	
	Dates of Eligibility: **From:** ___/___/_____ **To** ___/___/_____	**Patient Notified of Slide Fee?** [ ] Yes [ ] No

PATIENT RIGHTS AND RESPONSIBILITIES

Your Rights:

- You will not be discriminated against on the basis of income, race, color, national origin, sex, marital status, height, weight, arrest record, handicap or other grounds not permitted by applicable Federal, State, and Local laws and/or regulations
- To be treated with courtesy and respect in a culturally sensitive way by all Hope Clinic Staff
- All of your information is confidential
- You have the right to request a copy of your health information
- You have the right to privacy; people accompanying you will have to wait in the waiting area for you, unless instructed otherwise by you
- You have the right to receive the best possible care and have other options for care explained to you
- You have the right to refuse treatment to the extent permitted by applicable laws and regulations.
- You have a right to review a copy of any bills submitted to your insurance company
- You will not denied services because of inability to pay
- A translator will be available to assist you if you do not speak or understand English
- You have a right to information and explanations in the language you normally speak and in words that you understand
- You have the right to receive information regarding "Advance Directives" (End of Life Care)
- You have the right to consent for services provided at Hope Clinic

Your Responsibilities:

- Be on time for your appointment
- You are responsible for giving staff your accurate information about your present financial status and/or any changes in your financial status
- You are responsible for paying, or arranging to pay, all agreed fees for medical services, with the exception of dental services, which are provided on a prepaid basis.
- Come with custodial parent/legal guardian, if you are a minor, whenever possible
- Call Hope Clinic at least 24 hours in advance if you are unable to keep an appointment
- Provide Hope Clinic with current information on your insurance, address, name and phone number for follow-up
- Provide a complete and accurate medical history to staff
- Advice staff if you do not understand any aspect of your treatment
- Follow your medical/dental provider's recommendations and advice
- Tell us about unexpected complications that may happen during the course of your treatment
- Be considerate of the rights and privacy of other patients

You and your family have the right to have your compliments, concerns, and complaints be heard and addressed. Please call Hope Clinic and ask for a Management Team Member at 972-923-2440.

C L I N I C

Date: _____

Name: _____

DOB: _____

Medical History

Do you suffer from any of the following? (Please circle yes or no)

Allergic to local anesthetic	Yes	No	Arthritis	Yes	No	**Please List Your Current Medications**
Blood/Clotting Disorders	Yes	No	Depression	Yes	No	
Hardening of the Arteries	Yes	No	Skin Disease	Yes	No	
Chest Pain	Yes	No	Prosthetic Joint/Valves	Yes	No	
Swollen Ankles	Yes	No	Chemo/Radiation therapy	Yes	No	
High Blood Pressure	Yes	No	Treatment for Osteoporosis	Yes	No	
Heart Problems	Yes	No	Cancer	Yes	No	
Heart Murmur	Yes	No	Anemia	Yes	No	
Rheumatic Heart Disease/Fever	Yes	No	Seizures	Yes	No	
Stroke	Yes	No	Latex Allergy	Yes	No	
Prolonged Bleeding	Yes	No	Sterold Medication	Yes	No	
Tuberculosis	Yes	No	Organ Tranplant	Yes	No	
Emphysema	Yes	No	Urinary Tract Problems	Yes	No	**Have you had any surgeries?** If yes, please specify type and date below.
Fainting/Dizziness	Yes	No	Recreational Drug Use	Yes	No	
Ear/Nose/Throat Problems	Yes	No	Vision Problems	Yes	No	
Frequent Headaches	Yes	No	Asthma	Yes	No	
Hearing Problems	Yes	No	Aspirin Therapy	Yes	No	
Kidney Disease	Yes	No	Cough lasting 6 or more weeks	Yes	No	
Diabetes	Yes	No	Seasonal Allergies	Yes	No	
Thyroid Disease	Yes	No	Chronic Mental Illness	Yes	No	
Liver Disease	Yes	No	Glaucoma	Yes	No	
Hepatitis	Yes	No	Surgery with Rods/Pins/Screws	Yes	No	
Sexually Transmitted Disease	Yes	No	Allergy to Medication	Yes	No	
HIV/AIDS	Yes	No	Disease of Reproductive Organs? (Prostate, testicles, penis, uterus, ovaries, cervix) Please Specify:	Yes	No	**Have any blood relatives suffered from any of the following? If yes, specify which relative.**
Shortness of Breath	Yes	No				
Stomach/Intestinal Problems	Yes	No				Heart Disease
Are you Pregnant?	Yes	No	**When was your last immunization for:**			Cancer
Are you Breast-Feeding?	Yes	No	Tetanus			Blood Disease
Do you drink Alcohol?	Yes	No	Pneumonia			Hypertension
Do you use Tobacco?	Yes	No	Would you like assistance in quitting smoking?			Diabetes
						Kidney Disease

OB History (WOMEN ONLY)					
Date of last menstrual period		Is your:	Living/Deceased	**What Health Issues do/did they have?**	Stroke
# of Pregnancies		Father			Asthma
# of Living Children		Mother			Sickle Cell
Did you have gestational diabetes?		Sibling 1			Lung Disease
Were any babies over 9 pounds?		Sibling 2			Seizures
Are you using birth control? Type?		Sibling 3			Migraine
Are you menopausal?		Sibling 4			Gluacoma
Date of last mammogram:	Normal		Date of last well woman exam (pap smear):		Normal
Location:	Abnormal		Location:		Abnormal

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my Physician/Dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient/Guardian

Date _____

Patient Acknowledgement

Acknowledgement of Receipt of the Notice of Privacy Practices
This notice describes how health information about me may be used and disclosed and how I can get access to this information. Copies of our Notice of Privacy Practices may be found on our website, www.call4hope.org, under the Patient Information Section. You may also review this Notice in our patient lobbies, or ask for a printed copy at the front desk. I hereby acknowledge that I have reviewed a copy of the Hope Clinic Notice of Privacy Practice.

Initials: _____

Acknowledgement of Review of Patient's Rights and Responsibilities
This notice describes the patient responsibilities to Hope Clinic. I agree to all the conditions as described in the Patient's Rights and Responsibilities. If I have further questions regarding the Patient Rights and Responsibilities, I may direct them to the clinic staff.

Initials: _____

Consent for Treatment
I hereby and voluntarily consent to authorize the clinic's Providers to provide health care services to me at the clinic. 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 clinic'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). A person who signs a general consent for the performance of medical tests or procedures is not required to also sign or be presented with a specific consent form relating to medical test or procedures to determine HIV infection, antibodies to HIV, or infections with any other probably causative agent of AIDS that will be performed on the person during the time in which the general consent form is in effect. I understand that I will be asked to sign a separate informed general consent for vaccines administered to me and that I will be asked to sign a separate informed consent for the influenza (flu) vaccine. I understand that there is a separate consent form that I may be asked to sign for procedures performed in the office. 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 clinic, until I withdraw my consent, or until the clinic changes its services and asks me to complete a new consent form.

Initials: _____

Co-Pay Policy
Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patient to pay at EACH Visit. If proof of income is provided, you may qualify to use our sliding fee scale for services that are not covered by your insurance or for charges that are applied to your deductible. This does not apply to charges that require a co-pay or co-insurance payment determined by your Insurance Company. Thank you for your cooperation in this matter.

Initials: _____

Cancellation / No Show Policy
We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. If you do not cancel 24-hours prior to your appointment it will be considered a missed appointment. If you miss three (3) consecutive appointments, you may be discharged from care. The clinic will notify you in writing, via certified mail, if you are discharged from care.

Initials: _____

Cash-Pay Patients
I do not have health insurance and will be responsible for services rendered at Hope Clinic. I agree to pay the full and entire amount for treatment given to me or to the below named patient on the date services are rendered. I also understand that I will be considered as a "full-cost" patient if proof of income is not provided or if my income is above 200% of the Federal Poverty Level Guidelines.

Initials (write N/A if not cash-pay): _____

Authorization to Release Information

I hereby authorize any Hope Clinic staff or providers to engage in any verbal or written communication to the person(s) listed below regarding my medical history, medical records, appointments and/or information pertaining to my account and/or billing history with Hope Clinic. I understand that if I do not list any names that family members and/or friends will not be told any information regarding my visit(s) with Hope Clinic.

Initials: _____

_____ _____

Name Date

_____

Relationship

OK to leave message? ☐Yes ☐No Phone Number: _____

_____ _____

Name Date

_____

Relationship

OK to leave message? ☐Yes ☐No Phone Number: _____

_____ _____

Name Date

_____

Relationship

OK to leave message? ☐Yes ☐No Phone Number: _____

I further authorize Hope Clinic to release to agencies that I am being referred to, any information acquired in the course of my or the below named patient's examination and treatment as needed.

Initials: _____

I have read and understand the above information, and I agree to the terms described. I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient, I certify that I am authorized by law to agree to these conditions of treatment on behalf of the patient.

_____ _____

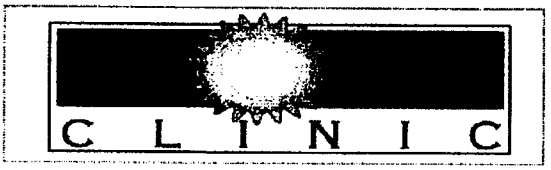
Patient Name Date

_____

Patient Signature

_____ _____

Guarantor Signature (If guarantor is not the patient) Print Guarantor Name



411 E Jefferson Waxahachie TX 75165
Phone: (972)923-2440 – Fax: (972)923-2445

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

I authorize Hope Clinic To

☐ **Release Health Care Information of the Patient Named Above To:**

☐ **Obtain Health Information From:**

Name: _____ **Phone:** _____

Address: _____ City: _____ State/Zip _____

( ) **All Medical or Dental Records** ( ) **Complete Transfer of Care**

Specified: _____ **Contact Person:** _____

Term:
This Authorization will remain in effect:

- ☐ From the date of this Authorization until the ____ day of _____, 201_.
- ☐ **Until the Provider fulfills this request.**
- ☐ Until the following event occurs:

1. You have the right to revoke this authorization in writing unless the Medical Records (PHI) have already been released or if otherwise prohibited by state or federal law.
2. Treatment, payment, enrollment or eligibility for benefits may not be a condition to release Medical Records (PHI). A signed authorization is a requirement in order for Medical Records (PHI) to be released.
3. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by above party and may no longer be protected by the federal HIPAA Privacy Rule. Hope Clinic will continue to maintain the confidentiality of our patient's medical records (PHI) mandated by the federal HIPAA Privacy Rule.

Definition: Sexually transmitted Disease (STD) as defined by law, includes herpes, herpes simples, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

If medical records are released directly to the patient, a fee of $15.00 for the first 20 pages and $0.25 for each additional page applies.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

If you are not the patient signing this form, what is your relationship to the patient?
_____ Legal Guardian _____ Parent of Minor _____ Power of Attorney

Summary of Privacy Practices

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

If you have any questions about this notice, please contact Hope Clinic's Privacy Officer at: (972)-923-2440.

WHO WILL FOLLOW THE PRIVACY PRACTICES DESCRIBED IN THIS NOTICE

This Notice of Privacy Practices ("Notice") describes the privacy practices of Hope Clinic (the "Clinic") and its workforce members (including employees, contractors, physicians, nurses, other licensed or certified personnel, volunteers, and front desk, billing and administrative personnel) who have a need to use your health information to perform their jobs. It also applies to any individuals authorized to enter information into your Clinic record. Your other health care providers may have different policies regarding their use and disclosure of your health information created at their location.

ABOUT YOUR HEALTH INFORMATION

We understand that health information about you and your health is personal, and protecting your health information is important to us. We create a record of the care and services you receive at the clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated Hope Clinic, whether made by clinic personnel or other health care providers.

We are required by law to:

- Maintain the privacy of health information that identifies you (with certain exceptions);
- Give you this Notice of our legal duties and privacy practices with respect to health information we collect and maintain about you; and
- Follow the terms of this Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories are different ways that we may use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- Disclosure at your request
- For Treatment
- For payment
- For health care operations

ADDITIONAL USES AND DISCLOSURES OF HEALTH INFORMATION

- As required by law
- Sign-In sheet
- Business Associates
- Fundraising
- Research
- Directory
- Appointment and patient recall reminders
- Disaster Relief
- Health-Related Products and Services
- To Avert a serious threat to health or safety
- Family, Friends, or other individuals involved in our care or payment of your care
- Change of Ownership of Hope Clinic

SPECIAL SITUATIONS

- Funeral Directors, Coroners and Medical Examiners
- Inmates and Law Enforcement
- Military and Veterans
- Organ and Tissue Procurement Organizations
- Public Health Reporting
- Worker's Compensation
- Multidisciplinary personnel teams
- Health Oversight Activities
- Lawsuits and Disputes
- National Security and Intelligence Activities
- Protective Services for the President and Others
- Victims of Abuse, Neglect, or Domestic Violence
- Security Clearances
- Special Categories of Health Information

YOUR PRIVACY RIGHTS

You have the following rights regarding health information we maintain about you:

- Right to obtain a paper copy of this Notice
- We reserve the right to accept or reject your request
- Request an accounting of disclosures
- Right to Request Confidential Communications
- Right to request Restrictions
- Right to Amend
- Right to inspect and copy

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed Notice effective for all health information we have about you as well as any information we receive in the future. We will post a copy of the current notice in the Clinic. The notice will contain the effective date on the bottom right corner. If we amend this Notice, we will offer a copy of the current Notice in effect.

You may request a detailed copy of the current Notice or a copy of this notice each time that you visit the Clinic for services or by calling the clinic and requesting that the current notice be sent to you by mail.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will stop the uses and disclosures allowed by that permission, except to the extent that we have already acted in reliance on your permission. For example, we are unable to take back any disclosures we have already made with your permission.

FOR MORE INFORMATION, TO FILE A COMPLAINT OR TO REPORT A PROBLEM

If you believe that your privacy rights have been violated, please let us know promptly so we can address the situation. You may file a complaint with the Clinic and/or with the Secretary of the Federal Department of Health and Human Services. All complaints must be submitted in writing.

To file a complaint with the Clinic, send a written complaint to the Clinic's Privacy Officer at:

Hope Clinic, 411 E Jefferson St, Waxahachie, TX 75165 ATTN: Privacy Officer
If you would like to discuss a problem without submitting a formal complaint, you may contact the Privacy Officer by telephone at (972) 923-2440; or by facsimile at (972) 923-2445.

You will not be penalized for filing a complaint.

5/2016