HOPE Family Health Center Registration Form

Please bring the following required documentation for registration.

Unfortunately, we cannot accept applications if any required documents are missing and/or if the application is not filled out in its entirety.

Proof of Identification:

- Driver's License
- State Identification Card
- Birth Certificate
- School ID (must be current)
- Passport
- Matricula
- Credencial de Elector
- LUPE Identification Card

Proof of Income:

- W2 or 8879 (or both)
- Last three (3) months' worth of check stubs
- Unemployment benefits documentation
- SNAP award letter (within last 3 months)
- TANF award letter (within last 3 months)
- SSI (SSA-1099 or award letter)
- SSDI (SSA-1099 or award letter)
- Self-employed or cannot produce these documents - Detailed and sealed notarized letter stating:
  - Applicant's name
  - What applicant does for work
  - How much applicant is paid
  - How often applicant is paid

Proof of Residence:

- Most recent light bill
- Most recent water bill
- Most recent gas bill
- Most recent phone bill
- Most recent internet bill
- Bank statement
- Rental agreement
- Sealed notarized letter stating applicant's name, address, and who s/he/they live with if applicant is not employed and lives with someone else, or if bills are under a person's name who doesn't live at the address.

Eligibility Specialist Hours

Monday	8:00AM – 12:00PM (Breanna, ext. 104) 1:00 PM – 4:00 PM (Mary, ext. 110)
Tuesday	8:00 AM – 12:00 PM (Breanna, ext. 104) 1:00 PM – 4:00 PM (Breanna, ext. 104)
Wednesday	8:00 AM – 12:00 PM & 1:00 PM – 4:00 PM (Breanna, ext. 104)
Thursday	8:00 AM – 12:00 PM (Breanna, ex. 104) 1:00 PM – 4:00 PM (Breanna, ext. 104)
Friday	8:00 AM – 12:00 PM (Mary, ext. 110)

HOPE
Family Health Center

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: | ❑ Mr. ❑ Mrs. | ❑ Ms. ❑ They/Them | 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 ❑ 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): ❑ Dr. _____ ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Social Media ❑ 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 ❑ TANF ❑ 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, 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

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.

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 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

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 understand that I am financially responsible for any procedures outside of HOPE volunteer's donated medical and counseling care.

Patient/Guardian Signature | *Date*

HOPE
Family Health Center

2332 Jordan Rd * McAllen Texas 78503 * T: (956) 994-3319 * F: (956) 971-9377

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 orign.

HOPE
Family Health Center

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 abour victims of abuse, neglect, or domestic violence; if the agency resonalbly 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 sercurity 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 exceptations. 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 dsisclosures of your health information that w emake 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.asx.

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 0%- 100% $5 de Donation per visit	Category B 100.01%-174.99% $10 de Donation per visit	Category C 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:

RIO GRANDE VALLEY HEALTH INFORMATION EXCHANGE
OPT-OUT REQUEST FORM

I understand that participation in RGVHIE is voluntary and that if I do not want to participate I can choose to "opt out" of including my health information in the RGVHIE system by signing this form.

CHOICE: INFORMATION NOT SHARED; CAN'T BE VIEWED IN AN EMERGENCY

I understand that by submitting this *HIE Opt-Out Request Form* my health information **WILL NOT** be included in the RGVHIE database and not be viewable by other health care providers.

I understand that by submitting this HIE OPT-OUT Request Form my health information **WILL NOT be available for health care providers to view in an emergency.**

I understand that I am free to revoke this Opt-Out Form at any time and can do so by completing a *RGV HIE Revocation of Opt-Out Form* that can be obtained from RGVHIE's website at www.rgvhie.org or from my health care provider.

I understand this request only applies to sharing my health information through the RGVHIE system. I recognize that when I see a health care provider for treatment that provider may request and receive my medical information from other providers using other methods permitted, like fax or mail.

Patient Name (First, Middle, Last)	
Previous Names	**Date of Birth (mm/dd/yyyy)**
Mailing Address	**City, State, Zip Code**
Contact Phone Number	**Email Address**

_____ _____

Signature of Patient **Date Signed**

If under 18 years, signature of parent or guardian

☐ **Parent** ☐ **Guardian** ☐ **Other**_____

_____ _____

Signature of Parent / Guardian **Date Signed**

_____ _____

Parent / Guardian Name **Parent/Guardian Contact Telephone**

RIO GRANDE VALLEY HEALTH INFORMATION EXCHANGE
REVOCATION OF OPT-OUT REQUEST FORM

I previously submitted a request to "opt out" of RGV HIE and am now requesting to be reinstated.

I understand that by submitting this *Revocation of HIE Opt-Out Request Form* my health information, **WILL** be included in the RGV HIE database and viewable by other health care providers. Sensitive information **WILL ONLY BE INCLUDED** if I also check the box below. Because treatment information sometimes includes sensitive health information about HIV/AIDS, behavioral health treatment, substance abuse or other issues, we need your consent in order to add your treatment information to the network. Please indicate whether you consent to having your sensitive information included.

☐ YES, I consent to sharing my sensitive health information through RGV HIE. ____Patient Initials

I understand that by submitting this *Revocation of HIE OPT-OUT Request Form* my health information **WILL be available for health care providers to view in an emergency.**

I understand this request only applies to sharing my health information through the RGV HIE system. I recognize that when I see a health care provider for treatment that provider may request and receive my medical information from other providers using other methods permitted, like fax or mail.

Patient Name (First, Middle, Last)	
Previous Names	**Date of Birth (mm/dd/yyyy)**
Mailing Address	**City, State, Zip Code**
Contact Phone Number	**Email Address**

_____ _____

Signature of Patient **Date Signed**

If under 18 years, signature of parent or guardian

☐ **Parent** ☐ **Guardian** ☐ **Other**_____

_____ _____

Signature of Parent / Guardian **Date Signed**

_____ _____

Parent / Guardian Name **Parent/Guardian Contact Telephone**

Acknowledgement of Notice of Privacy Practices

[Provider] participates in RioGrande Valley Health Information Exchange (RGV HIE) which is a nonprofit, community health information exchange that facilitates electronic exchange of patient information with physicians, hospitals, labs, pharmacies and other providers.

Sharing patient information with other providers through RGV HIE helps [Provider] provide better care for patients by not duplicating tests and having more complete information about patient's medication and other treatment history. In the future, RGV HIE will also connect to other HIEs to allow information to be available to other providers when patients travel outside of our region. See RGV HIE's brochure for more information about how RGV HIE helps us promote patient health and protects patient information. Patients can also read more about RGV HIE at www.rgvhie.org.

Because treatment information sometimes includes sensitive health information about HIV/AIDS, behavioral health treatment, substance abuse or other issues, we need your consent in order to add your treatment information to the network.

Patients may choose not to have any of their information shared through RGV HIE by signing an Opt-Out Form. You may request an Opt Out form from [Provider] staff. [Provider] will not discriminate against you if you choose to sign an Opt Out form and [Provider] does not require you to share information through RGV HIE in order to receive medical treatment.

- ☐ I consent to sharing my sensitive health information through RGV HIE and understand that [Provider] shares patient information including sensitive health information through RGV HIE. I may choose not to have my patient information shared through RGV HIE by signing an Opt Out Form. ___Patient Initials

Signed: _____ Date: _____

If under 18 years, signature of parent or guardian

[Contact information lines]

2332 Jordan Rd * McAllen Texas 78503* T: 956-994-3319 * F: 956-971-9377

*EMERGENGY CONTACT INFORMATION

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:_____

HOPE
Family Health Center

2332 Jordan Rd * McAllen Texas 78503* T: 956-994-3319 * F: 956-971-9377

*PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Patients of HOPE Family Health Center allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements of H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

*You have the right to revoke this consent

I do not Authorize Hope Family Health Center to Release Information to Family Members

Patient Signature: _____ Date: _____

I authorize Hope Family Health Center to release my records and any information requested to the following individuals.

1.) _____ Relation to Patient: _____

2.) _____ Relation to Patient: _____

3.) _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

_____ I authorize Hope Family Health Center to leave a detailed message on my home or cell number regarding appointments

_____ I authorize Hope Family Health Center to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

_____ I authorize Hope Family Health Center to leave a message with anyone who answers the phone

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____