Family Health Center- 1600 Providence Drive, Waco, Texas 76707

Please complete the following information and return to the receptionist.

PATIENT INFORMATION

PATIENT NAME_____

SEX AT BIRTH ☐ M ☐ F BIRTHDATE_____/_____/_____ SSN_____/_____/_____

PATIENT ADDRESS _____ APT # _____

CITY _____ST _____ZIP _____

HOME PHONE _____WORK PHONE _____CELL NUMBER _____

EMAIL _____

PREFERRED METHOD OF COMMUNITCATION ☐ Telephone ☐ E-mail (MyChart) ☐ US mail

EMERGENCY CONTACT _____RELATION TO PATIENT_____PHONE _____

PATIENT EMPLOYER_____OCCUPATION_____PHONE _____

Preferred Language
☐ ENGLISH
☐ SPANISH
☐ SIGNING / ASL
☐ OTHER_____

Ethnicity (check one)
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO

Race
☐ WHITE OR HISPANIC
☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN
☐ AMERICAN INDIAN OR ALASKA
☐ NATIVE HAWAIIAN
☐ OTHER PACIFIC ISLANDER

Marital Status (check all that apply)
☐ SINGLE
☐ MARRIED
☐ WIDOWED
☐ DIVORCED

Preferred Pharmacy
☐ FHC
☐ OTHER_____

Veteran Status
☐ ACTIVE DUTY
☐ DISCHARGED (VETERAN)
☐ NATIONAL GUARD
☐ RESERVES
☐ NONE

Gender Identity
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE / FEMALE-TO-MALE
☐ TRANSGENDER FEMALE / MALE-TO-FEMALE
☐ OTHER
☐ CHOSE NOT TO DISCLOSE

Sexual Orientation
☐ LESBIAN OR GAY
☐ STRAIGHT (NOT LESBIAN OR GAY)
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ CHOSE NOT TO DISCLOSE

Farmer Worker Status
☐ MIRGATORY FARM WORKER
☐ NOT A FARM WORKER
☐ SEASONAL FARM WORKER

In Public Housing
☐ NO
☐ YES

Are you living:
☐ DOUBLED UP (LIVING WITH OTHERS)
☐ IN A HOMELESS SHELTER
☐ ON THE STREET
☐ TRANSITIONAL HOUSING

What is your monthly household income?
_____

How many people are in your household?
(include yourself)
_____

BILLING & INSURANCE INFORMATION
PERSON RESPONSIBLE FOR ACCOUNT

NAME _____BIRTHDATE_____/_____/_____SSN_____/_____/_____

Relationship to patient_____

☐ **MEDICARE** PROVIDE COPY OF S.S. CARD ☐ **MEDICAID** ☐ **GOOD HEALTH CARD** ☐ **COUNTY** ☐ **TITLE V** ☐ **OTHER**

General Consent to Treat and Acknowledgement of Teaching Services

SIGN THIS FORM AND GIVE TO RECEPTIONIST

I hereby consent to any and all treatment that my Family Health Center (hereinafter "FHC") clinician and I agree is necessary for me or for the patient(s) I am guardian for.

I understand and acknowledge that FHC is a teaching center, and my care, and/or the care of patients(s) I am guardian for, at FHC may be provided by a clinician, including but not limited to medical students and/or resident physicians and/or resident dentists, in a clinical training program. I further understand and acknowledge that teaching services such as direct observation by other physicians or medical students, case discussions, or photographic or video images of care activities involving myself or my dependents are allowed for teaching purposes unless specifically denied by me.

I further understand that as part of its health care services, FHC's personnel and my clinician create and maintain a record of care and services provided. I understand that such information may be used and/or disclosed in the management and delivery of care and services provided by FHC, as described in the Notice of Privacy Practices. I understand and acknowledge that FHC participates in an electronic health record exchange program, and that if I seek treatment from other healthcare facilities or providers participating in this exchange program, my health information, or that of the patient(s) I am guardian for, may be shared between FHC and those other facilities or providers. I understand and acknowledge that as part of receiving my healthcare at FHC, FHC's clinicians and other personnel may electronically request and/or provide health records for me and/or patient(s) I am guardian for, to those participating facilities or providers. These records include, but are not limited to prescription medication history, as well as information related to mental health treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment, and/or HIV (AIDS) testing/results and/or treatment. I further understand that any such information from any source whatsoever may become part of the requesting party's health records on me and/or the patient(s) I am guardian for.

NOTICE OF PRIVACY PRACTICES

I hereby understand that I have the right to request a copy of the Family Health Center's Notice of Privacy Practices.

LIMITED ENGLISH PROFICIENCY

The Family Health Center proudly offers certain language assistance to its patients free of charge. We also strive to make reasonable accommodations for its disabled patients.

PHOTOGRAPHY

I consent to the taking of photographic and/or video images for the purpose of identification and documentation of my medical care.

STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby understand I am the person primarily responsible for payment of all charges for services rendered by FHC, regardless of any insurance coverage I might have, including Medicare or Medicaid, and that such payment is due on demand. I further understand that in addition to such service charges, I will be liable for any court costs, attorney's fees, collection expense, or interest that may be incurred should such actions be required to obtain payment for services rendered by FHC. I certify that the patient and financial information given at the time of services rendered is accurate and complete.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of service rendered, I hereby irrevocably assign and transfer to FHC, all rights, title and interest in benefits payable for services rendered by FHC. I hereby authorize and instruct the insurance company (including but not limited to Medicaid, Medicare, County, Champus, and commercial carriers), to pay directly to FHC all benefits due under the terms of my policy or policies. I will pay FHC for all non-covered charges or for all legally allowed charges in excess of whatever sums may be paid by the insurance company.

MEDICAID/MEDICARE ACKNOWLEDGMENT

I have been informed by a FHC healthcare provider that some services/items I request, including those provided to me on _____ (date), may not be covered under the Medicaid and/or Medicare Programs as being reasonable and medically necessary for my care. I understand that the Medicaid and/or Medicare Programs, or their health-insuring agent(s), determine the medical necessity of services/items I request and receive. I also understand that I am responsible for payment of services or items I request and receive if these services/items are determined by Medicaid and/or Medicare not to be reasonable and medically necessary for my care.

OUTSIDE DIAGNOSTIC CHARGES

As of 6/1/95, laboratory testing for specimens/x-rays/ultrasounds obtained at FHC and sent to a radiologist or independent lab will be billed to me directly from that independent facility (listed below). There is also a lab handling fee for obtaining lab specimen(s) which is billed through FHC. Upon receiving a statement, I understand that I am to contact that laboratory or radiology department to arrange payment or exchange insurance information. I have been informed in writing and verbally of this change. I understand that these diagnostic charges are now my responsibility.

INDEPENDENT DIAGNOSTICS: Hillcrest Baptist Medical Center - interpretation and procedure of lab or x-rays/ultrasound; Radiology Consultants of Texas; Clinical Pathology Lab – lab tests not performed at FHC; Central Texas Pathology – pap smears, tissue or surgical pathology. Certain other outside diagnostic services as necessary may also be billed directly to the patient by service providers not listed above.

PATIENT /GUARDIAN SIGNATURE

I have read and understand the aforementioned document.

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN* SIGNATURE _____

RELATIONSHIP TO PATIENT _____

WITNESS _____

Legal guardian must provide proof of guardianship, a copy of which must be attached to this form.

Family Health Center

Authorization to Access Information

I _____,
(printed name & date of birth)

hereby authorize Family Health Center staff to disclose any and all of my health information to the following individual(s) until further notice is given.

_____	_____
(name)	(relationship)
_____	_____
(name)	(relationship)
_____	_____
(name)	(relationship)

_____ _____

Patient Signature Date

For Clinic Use Only: Approved CPIC 4/10/13

Appropriate identification has been presented and verified.
Name of staff member/department:_____
Clinic Name:_____ Date:_____