Today's Date: Primary Care Provider (PCP):

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Gender: ❑ M ❑ F ❑ other
Parent/Guardian Name:			Sexual Orientation: ❑ Straight or heterosexual ❑ Refused to report ❑ Bisexual ❑ Other ❑ Lesbian, gay or homosexual ❑ Unknown		
Street address:			P.O. Box:	City:	
Social Security Number:	Daytime #:	Alternate Phone Number:	State:	ZIP Code:	
Email:				Contact Preference: ❑ Daytime ❑ Alternate ❑ Email ❑ No Contact	
Occupation:	Employer:			Employer Phone Number:	
Language(s) Spoken:	Veteran? ❑ Yes ❑ No	Agricultural Worker? ❑ Yes ❑ No	Homeless? ❑ Yes ❑ No		
Race:	❑ White ❑ Black/African American ❑ Asian ❑ Native Hawaiian ❑ Pacific Islander ❑ American Indian/Alaskan Native ❑ Unreported/Refused				
Ethnicity: ❑ Hispanic ❑ Not Hispanic ❑ Unknown		Do you need a translator? ❑ Yes ❑ No Type: _____			
Do you live in public housing? ❑ Yes ❑ No		If yes, is it a high rise, low rise, section 8 or other? (circle one)			
Number of Immediate Family in Household: _____ Monthly Household Income $_____		Primary Caregiver: Phone Number:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber Information:	Birth date: / /	Address (if different):		Daytime Phone Number:
Is this person a patient here?	❑ Yes	❑ No	SSN#	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:	Daytime Phone Number:	Alternate Phone Number:

Authorized to release information ❑ Yes ❑ No Do you have Advanced Directive or Living Will ❑ Yes ❑ No

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Community Health Service Agency, Inc. or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature ***Date***

Amistad Community Health Center, Patient Acknowledgement

_____ _____
Print Patient Name Date of Birth

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.
I hereby acknowledge that I have received a copy of the Amistad Community Health Center, Notice of Privacy Practice.
Effective Date: April 14, 2003; updated with HIPAA Omnibus Rule: September 23, 2013. Initials: _____

Acknowledgement of Review of Patient's Rights and Responsibilities
This notice describes the patient responsibilities to Amistad Community Health Center. I agree to all the conditions treatment at Amistad Community Health Center, 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 center staff. Initials: _____

Consent for Treatment
I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services to me at the center's service locations. 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 center'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 infection with any other probable 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 center, until I withdraw my consent, or until the center 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 patients 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 copay or co-insurance payment. 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 no show for three (3) consecutive appointments in a year, you may be discharged from care. The clinic will notify you in writing, via certified mail, if you are discharged from care. Initials: _____

Self-Pay
I do not have health insurance and will be responsible for services rendered at Amistad Community Health Center. I agree to pay the full and entire amount for treatment given to me or to the above named patient on the date services are rendered. I also understand that I will be considered as a "full-pay" patient if proof of income is not provided within 6 months of my first visit for the sliding fee scale.
Initials: _____

Authorization to Release Information
I hereby authorize any Amistad Community Health Center staff or provider 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 Amistad Community Health Center. I authorize Amistad Community Health Center staff and/or provider to leave health information on a voicemail and/or answering machine at the number(s) listed on the following page.

I further authorize Amistad Community Health Center, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment. Initials: _____

Amistad Community Health Center, Patient Acknowledgement

_____ _____
Print Patient Name Date of Birth

Termination

We can decide to stop treating you as a patient. If we stop treating you as a patient, you have a right to advance notice that explains the reason for the decision, and you will be given 30 days to attempt to find other health services. After notice of termination, we will only provide urgent care for a 30 day period while you find a new provider. WE can decide to stop treating you immediately and without notice, if we have determined that you have created a threat to the safety of the staff and/or other clients. You also have a right to receive a copy of our termination policy. Other reasons for which we may stop seeing you include: failure to obey our rules, failure to keep scheduled appointments three (3) times, intentional failure to report accurate information concerning your health, intentional failure to follow the health care program, such as instructions about taking medications, personal health practices, or follow-up appointments, as recommended by your doctor, creating a threat to the safety of the staff and/or other clients, and/or loud verbal or physical abuse or harassment of Center staff, and intentional failure to report accurately your financial status. If we have given you notice of termination, then you have the right to appeal the decision to the Board of Directors.

I have received a copy of this document in brochure form. Initials: _____

After hours

Hours of operation: Monday- Thursday: 8 a.m. – 9 p.m.

Friday: 8 a.m. – 5 p.m.

Saturday: 9 a.m. – 2 p.m.

If contacting after-hours call 361-884-2242 option 7

I acknowledge and understand Amistad's after hour's procedure. Initials**:** _____

Questions

Is our location appropriate: Yes ❑ or No ❑

Is our Nominal Fee appropriate: Yes ❑or No ❑

Are our Hours of Operation appropriate: Yes ❑ or No ❑

Amistad Community Health Center, Patient Acknowledgement, HIPAA Release

_____ _____
Print Patient Name Date of Birth

To whom may we release medical information:

_____ _____
Name: Date:

_____ Phone Number: _____
Relationship:

OK to leave message ☐ YES ☐ NO

Release of Medical Records ☐ YES ☐ NO

_____ _____
Name: Date:

_____ Phone Number: _____
Relationship:

OK to leave message ☐ YES ☐ NO

Release of Medical Records ☐ YES ☐ NO

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 Signature Date

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