Community Healthcare Center
Reaching Out To Everyone

WELCOME TO COMMUNITY HEALTHCARE CENTER… ***Your health is our #1 priority!***

Community Healthcare Center is proud to announce adoption of the "Medical Home" model of health care. This new, innovative, team-based approach to providing health care focuses on the partnership between you the patient, and the Center's health care team. We will work together to coordinate the services you need and provide the best care possible.

HOURS

Medical		
• **Clinic**	**Monday through Friday**	**7:00 a.m. to 6:00 p.m.**
• **Juarez Site**	**Monday through Friday**	**8:00 a.m. to 5:00 p.m.**
• **Family Health Center**	**Monday through Friday**	**8:00 a.m. to 5:00 p.m.**
TodayCare		
• **Adults & Children**	**Monday through Friday**	**7:00 a.m. to 5:30 p.m.**
• **Adults & Children**	**Saturday**	**8:30 a.m. to 12:00 p.m.**
Dental		
• **Clinic**	**Monday through Friday**	**8:30 a.m. to 5:30 p.m.**
• **Dental Walk-In**	**Monday through Friday**	**8:30 a.m. to 5:30 p.m.**
Pharmacy	**Monday through Friday**	**8:00 a.m. to 5:30 p.m.**

MINORS

Patients under 18 years of age must be accompanied by a parent or legal guardian in order to receive routine treatment. Legal guardians must bring proof of guardianship.

SERVICES and STAFF

We offer the following services: primary medical care, primary dental care, pediatric care, prenatal care, counseling, lab, X-rays and ultrasound, screening tests, immunizations, pharmacy, and eligibility assistance.

PAYMENT FOR SERVICES RECEIVED

Fees charged are on a sliding fee scale based on your household income. Payment should be made at the time of service. Community Healthcare Center welcomes Medicare, Medicaid, CHIP, TRICARE, insurance, cash, checks, and credit cards.

AFTER HOURS

If you have a **medical illness** that cannot wait until Community Healthcare Center opens, you may call the Center at 940-766-6306 and speak to the "after hours" nursing service. You will be given advice on how to handle your illness. This service is not to be used for medication refills, appointment scheduling or billing issues. If you have a **dental emergency**, we do have walk-in availability during normal business hours.

PRESCRIPTIONS

The pharmacy fills prescriptions for patients of Community Healthcare Center only. Unplanned refills require a **minimum** of 48 hours for completion. A follow-up visit will be scheduled every three months for maintenance medications, unless otherwise noted by your primary care provider. There are several ways our patients can be assisted with prescription costs. Please ask your provider or the pharmacy about these services. Controlled substances are not stocked onsite.

FUTURE VISITS – IT IS IMPORTANT TO KEEP YOUR APPOINTMENTS

Remember to bring your medications to every visit. Should your work situation, insurance coverage, or address change, it is your responsibility to make us aware of those changes. **When you know you cannot keep your appointment, please make every attempt to cancel the day before. This will allow us to help another patient.**

Patient's Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Parent/Guardian Name: _____ Date of Birth: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Alternate #: _____ Email Address: _____

Employer: _____ Work #: _____

Emergency Contact: _____

Relationship to patient: _____ Phone #: _____

Insurance Company: _____ Policy Holder: _____

Policy Holder's DOB: _____ ID #: _____ Group #: _____

To meet new requirements for our funding sources, we need the following information on each patient. Thank you for your assistance!

What is your race? (Check the box that applies)	**What is your ethnicity? (Check the box that applies)**
☐ Asian ☐ African American ☐ American Indian ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ More than one race ☐ Unreported _____ (staff initial)	☐ Latino ☐ Non-Latino ☐ Not reported _____ (Staff initial)
Are you a US Veteran? ☐ Yes ☐ No **Are you a farm worker?** ☐ Yes ☐ No If yes: ☐ Migrant or ☐ Seasonal	**Do you live in public housing?** ☐ Yes ☐ No **Are you homeless?** ☐ Yes ☐ No If yes, please check the correct description: ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street
What is your sexual orientation/gender identity? Please check the box that applies.	
Sexual Orientation: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bi-Sexual ☐ Other ☐ Unknown ☐ Decline to Answer _____ (staff initial)	**Gender Identity:** ☐ Male ☐ Female ☐ Transgender Male (FTM) ☐ Transgender Female (MTF) ☐ Unknown ☐ Neither exclusively male or female ☐ Other ☐ Decline to Answer _____ (staff initial)

Notice of Privacy Practices:

☐ I have received the Community Healthcare Center's Notice of Privacy Practices.

Rights and Responsibilities:

☐ I have received Community Healthcare Center's Notice of Rights and Responsibilities.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Date

Community Healthcare Center
Signature on File

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to Community Healthcare Center, for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that; payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature: _____ Date: _____

Medicare #: _____

Medicaid #: _____

Insurance Company: _____ Policy #: _____

NOTICE CONCERNING COMPLAINTS: Complaints about physicians, as well as other licensees and registrants of the Texas Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners, Attention: Investigations, 1812 Center Creek Drive, Suite 300. P.O. Box 149134, Austin Texas 78714-9134

Assistance in filing a complaint is available by calling the following number:

1-800-201-9353

Community Healthcare Center
GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better information about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: Community Healthcare Center, (Hereinafter called the "Center") encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Center services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Center cannot assume the responsibility for payment of medical care received or performed outside the Center, including the delivery of babies, reference lab and/or other diagnostics, etc., even if such care was ordered by Center providers, unless previous authorization has been given by Center's Administration.

DISCLAIMER: Among its services, the Center utilizes screening tests, including certain blood tests, which are a method of identifying individuals who are at risk for developing several common medical problems. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the Center, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form. Parental consent is not required for prenatal care of patients who are still minors.

INFORMED UNDERSTANDING: I understand that no warranty or guarantee has been made to me as to the result of cure from care and treatment provided.

RELEASE OF INFORMATION: I further understand that all Medical and Social Service Records may be released to representative of the United States Department of Health and Human Services and to representatives of programs or projects funded by this Department and other funding sources for the purposes of determining contract compliance with Federal/State law and regulations. Family Health Center utilizes the MED-IT system for Breast and Cervical Cancer Services (BCCS), and IMMTRAC for immunizations.

CONTRACT PHARMACIES: I understand that Community Healthcare Center provides services through contract pharmacies and/or other venders and my personal health information may be shared with these pharmacies and/or other venders so that I can receive improved access to affordable medications and/or healthcare.

TEACHING FACILITY: I understand and acknowledge that Community Healthcare Center is a teaching center, and my care, and/or the care of patient(s) I am a guardian for, may be provided by a clinician, including but not limited to medical subtends 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 physician and medical students, case discussions, or photographic or video images of care activities involving myself or my dependents are allowed for teaching.

Community Healthcare Center
GENERAL CONSENT AND DISCLOSURE

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in, and that any questions I have had about the service have been answered to my satisfaction. I further certify that I have read or had read to me* the *Client and Center Rights and Responsibilities* and accept that document.

SIGNATURES: Fill blank lines with NA if not applicable.

SECTION I:

Patient's Name _____ Signature _____
Person Authorized to Consent (if not patient) _____ Relationship _____
Signature _____ Date _____

SECTION II:

Witness Signature _____
Date _____

*Translated into _____/ Read to me
by _____
Signature of Person translating or reading consent to patient:
_____

Date: _____ Client #: _____

Community Healthcare Center
Reaching Out To Everyone

CHC Sliding Fee Application

_____ _____
Last Name First Name

_____ _____
Date of Birth Phone

Are you employed? Yes No _____
Name of Employer

Do you receive: Social Security Unemployment?

Please list spouse and dependents living in your household:

Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____

By my signature below I attest that the information provided herein is complete and accurate. I understand that I may I be required to provide additional information and documentation upon request for the purpose of determining my eligibility to participate in the Sliding Fee Discount Program. I agree to inform CHC of any changes of condition or circumstance that might impact my eligibility to participate in the Discount Program. I understand I am responsible for a minimum payment of at least $30 at the time of each medical visit unless other arrangements have been made.

_____
Patient/Guardian Signature Date

Office Use only

Household Income: $_____ Family Size: _____ Account #: _____

Percentage of Discount: _____% Expiration Date: _____

Staff Signature _____ PM System Updated: YES NO

Community Healthcare Center

Please circle the letter over the column that represents your Family Size and Household Income.

Annual Family Income				
Family Size	A 100% & Below	B 101-150%	C 151-200%	D Over 200%
1	$12,490 or less	$12,491 - $18,859	$18,860 - $24,980	More than $24,980
2	$16,910 or less	$16,911 - $25,532	$25,533 - $33,820	More than $33,820
3	$21,330 or less	$21,331 - $32,206	$32,207 - $42,660	More than $42,660
4	$25,750 or less	$25,751 - $38,880	$38,881 - $51,500	More than $51,500
5	$30,170 or less	$30,171 - $45,554	$45,555 - $60,340	More than $60,340
6	$34,590 or less	$34,591 - $52,227	$52,228 - $69,180	More than $69,180
7	$39,010 or less	$39,011 - $58,901	$58,902 - $78,020	More than $78,020
8	$43,430 or less	$43,431 - $65,575	$65,576 - $86,860	More than $86,860
9	$47,850 or less	$47,851 - $72,249	$72,250 - $95,700	More than $95,700
10	$52,270 or less	$52,271 - $78,922	$78,923 - $104,540	More than $104,540

Patient/Guardian Signature _____

Account Number: _____ Date: _____

Revised 03/19/2019

Community Healthcare Center

Reaching Out To Everyone

HIPAA Release of Information

Patient Name: _____ Date of Birth: _____

Please list anyone you give us permission to speak with regarding your protected health information. This information may include: diagnosis, test results, recent visits, medication requests, appointment information, and billing/insurance information.

I authorize the release of my personal health information to the following:

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB _____

This authorization will remain in effect until revoked by me in writing.

_____ _____

Signature Date

_____ _____

Witness Date

This does not authorize copies of protected health information to be released, mailed, or faxed to the person(s) listed. To obtain paper copies of protected health information, a valid HIPAA release is required.

Effective January 30, 2018 Chart # _____