South Texas Rural Health Services, Inc. Registration Form
Medical Record Number_____

PATIENT INFORMATION SECTION/Información del solicitante ***Verbal translation available

Name (Last, First, Middle) Nombre (Apellido, primero, Segundo)			
Mailing Address/ Direccion de envio	**City/** Ciudad	**State/**Estado	**Zip Code/**Codigo Postal

Home Phone/Telefono	**Work Phone/** Telefono del trabajo	**Cell Phone/** Telefono Movil

E-Mail /correo electronico (required for Patient Portal Autoflow)	**Contact Method/** Metodo de contacto	**Marital Status/**Estado Civil
	☐ Home Phone ☐ Mail ☐ Voice Reminder ☐ Cell Phone (Text) ☐ E-Mail	☐ Single ☐ Married

Date of Birth Fecha de nacimiento		**Birth Sex**	☐ Male ☐ Female	**SSN/**Num De Seguro Social

Race/Raza ☐ White ☐ Black ☐Asian ☐ Hawaiian ☐Pacific Islander ☐American Indian ☐More Than One Race ☐ Choose Not To Report	**Ethnicity** ☐ Hispanic ☐ Not Hispanic	**Veteran** ☐ Yes ☐ No	**Preferred Language?** ☐ English ☐ Spanish	**Citizen/** Ciudadano estadounidense ☐ Yes ☐ No

Have you ever worked in agriculture (farm work)? ☐ **Yes** ☐ **No If NO Stop Here and go to Responsible for Payment line.**
If YES, have you worked in agriculture in the last 24 Months ☐ **Yes** ☐ **No If YES skip the next question**
Or Did you retire from agriculture work due to age or a disability ☐ **Yes** ☐ **No**☐
Did you work in the area where you live (Seasonal) ☐ **OR Did you relocate to live somewhere else to work (Migrant)** ☐

HEAD OF HOUSE Adult Required for Minors	**DOB**	**Address**	**Phone**	**Relationship**

Emergency Contact Name		**Phone #**		**Relationship**	

If you have no insurance, check off box ☐
OR
Complete this section for medical and/or dental insurance you currently have.
Present all insurance cards for a photocopy. If your employer pays record employer as payer.

Medical Insurance/Payer Name	**ID Number**	**Subscriber Name**	**Subscriber Date of Birth**	**Relation to Insured**
Dental Insurance/Payer Name	**ID Number**	**Subscriber Name**	**Subscriber Date of Birth**	**Relation to Insured**

If you have another primary doctor, were you referred to us ?	☐ Yes ☐ No **If Yes, list Dr. Name and Ph. Below:**
Primary Doctor Name	**Phone Number**

If no discount is requested check REFUSE TO REPORT, check off box ☐ **Comments:**

STAFF USE ONLY: Complete this section if patient wants to qualify for sliding fee discount.

Total Annual Family Income Staff Attach Calculator Tape		**# of Family Members including yourself**		**Poverty Category Staff Use Only**	

I certify the information provided above is true and correct. I understand I am responsible for payment of services not covered by health insurance, if applicable. I release insurance information and authorize payment directly to STRHS, Inc. I understand payment is expected as services are rendered and no refunds will be made for services provided.

Signature Patient/Parent/Legal Guardian / Firma	**Date /** Fecha	**Signature STRHS Staff**	**Date /** Fecha

South Texas Rural Health Services, Inc.

Consent for Treatment of an Adult

Name of Patient: _____ **Date of Birth:** ____/____/____

Name of person giving consent is different from Patient:

[Print Name]: _____

Relationship to Patient: □ Self □ Parent □ Guardian □ Other: _____

I hereby and voluntarily consent to authorize the Center's healthcare providers, including its physicians, midlevel providers (Physician Assistants, Advance Practice Nurses) and dentists at their service locations to provide health care services to me. 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 (such as blood, urine, HIV and other studies), x-rays and other imaging studies, heart tracing (EKG), administration of medications, as well as procedures and treatment prescribed by the Center's medical and/or dental Staff. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that there are no guarantees being made to me concerning the results of the treatment provided or the effectiveness of any birth control methods prescribed for me.

I understand that this consent is valid and remains in effect as long as I am a patient of the Center.

Consent Provisions

My signature on this form indicates that: (1) I acknowledge that the informed consent for medical treatment and/or procedures ("Treatment") at the Center has been adequately explained to me by the Center's Physician, Physician Assistant, or other qualified Healthcare Provider; (2) I have received all of the information that I desire concerning the Treatment; (3) I have had the opportunity to obtain answers to my questions concerning the nature of the Treatment, its expected benefits, potential discomforts/side effects/risks, and any and all alternatives (and their risks and benefits), and the consequences of not receiving Treatment; (4) I understand that as with all medical treatment, there is a possibility that complications other than those described to me or in this form may occur, and that no guarantee is made regarding the outcome of my Treatment; (5) I realize that although every effort will be made to keep all risks and side effects to a minimum; risks, side effects, and complications can be

unpredictable both in nature and severity; (6) I understand that "Midlevel Providers" (Physician Assistants, Advance Practice Nurses) will be involved in my Treatment and I consent thereto; (7) I have carefully read and understand the information presented to me and in this informed consent form; (8) I hereby voluntarily give my consent to Treatment at the Center; (9) I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require a separate informed consent form; and (10) I acknowledge that I have been fully informed of my right to receive a copy of this signed and dated informed consent form.

By signing this consent I authorize the Center to enter/view clinical services/data history stored in Med-IT or an electronic health record (EHR).

By: _____
[Signature of Patient/Legal Representative]
Print Name: _____
Date/Time: _____ A.M./P.M.

If signed by other than Patient, indicate relationship: _____
_____

By: _____
[Signature of Witness]

Print Name of Witness: _____
Date/Time: _____ A.M./P.M.

Translator to complete when applicable:

I have accurately and completely read the foregoing document to: _____
_____
[Insert the Patient's or Patient's Legal Representative's name]
in _____, the Patient's or Patient's Legal Representative's primary language. S/He understood all of the terms and conditions and acknowledged his/her agreement and consent thereto by signing the document in my presence.
Translated By: _____
[Signature of Translator]
Print Name of Translator: _____
Date/Time: _____ A.M./P.M.

PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES

Name: _____Date of Birth: ____/____/____Chart #: _____

Welcome to the Center. Our goal is to provide quality health care to qualified persons in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. The Center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read and sign this statement and ask us questions you might have.

A. Human Rights

You have a right to be treated with respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age (over 40), Vietnam era veteran status, or other grounds not permitted by applicable federal, state and local laws or regulations.

B. Payment For Services

1. You are responsible for giving Staff accurate information about your present financial status and any changes in your financial status. The Staff need this information to decide how much to charge you and/or so they can bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, you will be charged a discounted fee.

2. You have a right to receive explanations of the Center's bill. You must pay, or arrange to pay, all agreed fees for medical services, with the exception of dental services, which are provided on a prepaid basis. If you cannot pay right away, please let Staff know so they can provide care for you now and work out a payment plan.

3. Federal law prohibits the Center from denying you primary health care services which are medically necessary, solely because you cannot pay for these services.

C. Privacy

You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private. Only legally authorized persons may see your medical records unless you request in writing for us to show them to, or copy them for, someone else. A complete discussion of your privacy rights will be given to you along with this document and is named the Center's Notice of Privacy Practices. Staff will request that you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices sets forth the ways in which your medical records may be used or disclosed by the Center and the rights granted to you under the Health Insurance Portability and Accountability Act ("HIPAA").

D. Health Care

1. You are responsible for providing the Center complete and current information about your health or illness and current medications so that we can give you proper health care. You have a right, and are encouraged, to participate in decisions about your treatment.

2. You have a right to information and explanations in the language you normally speak and in words that you understand. You have a right to information about your health or illness, treatment plan, including the nature of your treatment; its expected benefits; its inherent risks and hazards (and the consequences of refusing treatment); the reasonable alternatives, if any (and their risks and benefits); and the expected outcome, if known. This information is called obtaining your informed consent.

3. You have the right to receive information regarding "Advance Directives." If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to your legally authorized representative.

4. You are responsible for appropriate use of Center services, which includes following Staff instructions, making and keeping scheduled appointments, and requesting a "walk in" appointment only when you are ill. Center professionals may not be able to see you unless you

have an appointment. If you are unable to follow instructions from the Staff, please tell them so they can help you.

5. If you are an adult, you have a right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of your refusing such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed." You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in your best interest, you may be asked to sign a Refusal to Permit Medical Treatment or Services form or Against Medical Advice form (as appropriate).

6. You have a right to health care and treatment that is reasonable for your condition and within our capability, however, the Center is not an emergency care facility. You have a right to be transferred or referred to another facility for services that the Center cannot provide. You have a right to seek a second opinion on your condition. You have a right to obtain care from other clinicians of your chose within the agency. The Center does not pay for services that you receive from another healthcare provider.

7. If you are in pain, you have a right to receive an appropriate assessment and pain management, as necessary.

E. Center Rules

1. You have a right to receive information on how to appropriately use the Center's services. You are responsible for using the Center's services in an appropriate manner. If you have any questions, please ask us.

2. You are responsible for the supervision of children you bring with you to the Center. You are responsible for your children's safety and the protection of other patients and our property.

3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments you may be asked to meet with the Center's CEO to determine the reason for your missed appointments and whether you can continue as a patient of the Center.

F. Complaints

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Staff will tell you how to file a complaint.
2. If you complain, no Center representative will punish, discriminate or retaliate against you for filing a complaint, and the Center will continue to provide you services.

G. Termination

If the Center decides that we must stop treating you as a patient, you have a right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find other health care services. However, the Center can decide to stop treating you immediately, and without written notice, if you have created a threat to the safety of the Staff and/or other patients. You have a right to receive a copy of the Center's Termination of the Patient and Center Relationship Policy and Procedure.
Reasons for which we may stop seeing you include:

1. Failure to obey Center rules and policies, such as keeping scheduled appointments;
2. Intentional failure to report accurately your financial status;
3. Intentional failure to report accurate information concerning your health or illness;
4. Intentional failure to follow the health care program, such instructions about taking medications, personal health practices, or follow up appointments, as recommended by your healthcare provider(s), and/or

5. Creating a threat to the safety of the Staff and/or other patients.

H. Appeals

If the Center has given you notice of termination of the patient and Center relationship, you have the right to appeal the decision to the CEO.
Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

I. Notice

This health center is a Health Center Program grantee under 42 U.S.C. 254b, and a deemed Public Health Service employee under 42 U.S.C. 233(g)-(n).

By: _____ ____/____/____
Signature **Date**

Name: _____
[Print Name]

SOUTH TEXAS RURAL HEALTH SERVICES, INC.
INSURANCE ACKNOWLEDGMENT FORM

Patient Name: _____ Medical Record #: _____

Do you have the following:
( ) Medicare

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediates or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who may accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may responsible for paying for my treatment. (Section 1128 B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature_____Date_____

( ) Medicaid

"I understand that, in the opinion of **The STRHS, Inc. Provider**, the services or items
Name of Provider
that I have requested to be provided to me on **January 01, 2020 - December 31, 2020** may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Health or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

_____ _____
Client Signature Witness (Employee)

_____
Date

( ) Other Private Insurance

Assignment of Insurance Benefits Consent:

(a) I authorize the clinic to release any information to third party insurance carriers for the purposes of filing insurance claims related to my (his/her) medical care.
(b) I authorize payment of medical benefits to the undersigned physician or supplier for services. I agree to submit copies of my insurance card to the clinic for the record. I furthermore agree to pay:
    1. all deductible amount in full
    2. any percent of the charges according to type of coverage I have
    3. any amount of charges not covered by the insurance
(c) I furthermore authorize the release of medical information about treatment here to my (his/her) doctor or any designated by me.

I understand that this consent will remain effective unless otherwise specified by me or upon cancellation of the insurance coverage.

_____ _____
Signature Date

SOUTH TEXAS RURAL HEALTH SERVICES, INC.
POLICY: ACCEPTING OF PRIVATE INSURANCE, SCHOOL INSURANCE
Revised: 06/2019

POLICY

This policy is to define assignment of private insurance, for medical and dental services. Patients who have Private Insurance must use their insurance; however Sliding Fee Scale will apply to ANY DEDUCTIBLE AND CO-PAY AMOUNTS.

Since Deductible and Co-Pay amounts will be based on the Sliding Fee Scale. Emphasize to the patient the benefit of providing insurance information and having the Sliding Fee Scale apply.

All patients must sign the Insurance Acknowledgement in the appropriate section, Medicare, Medicaid or Private Insurance.

PRIVATE INSURANCE PROCEDURE

1. Assignment of private insurance will be accepted. *A social security number is required belonging to the patient being seen in order to accept private insurance.*

2. If the patient would like to participate in the Sliding Fee Scale for their Co-Pay, follow the normal Registration Certification for Eligibility Procedure.

3. All insurances, including Medicaid, will be verified by assigned staff. Call the Insurance Company while the patient is on-site and/or use Real-Time Eligibility in Next Gen, prior to the patient seeing the provider. Verification at each visit will be documented and be kept in the Medical Record with the Registration. Please Note: Each on each visit the insurance must be verified. If the insurance claim is denied, this will be checked to determine if the insurance was verified on the date of service.

    3a. If, the insurance requires providers to be enrolled, determine if STRHS, Inc. an enrolled provider.

    3b. If, STRHS, Inc. is not an enrolled provider, request enrollment forms.

    3c. Request from the insurance, approval for an exception to enrollment, to provide immediate services.

    3d. If exception approval is not available, inform the patient and request payment from the patient for any services provided. Explain the enrollment process and inform the patient of the steps we will take to become enrolled.

4. Any required co-pay or deductible will be collected as services are rendered. Transfer to self-pay Ledger and apply Sliding Fee Scale.

5. Deductible and co-pay amounts are posted to the self-pay ledger. Balance Transfer from the Insurance Ledger any deductible or co-pay amounts collected.

Accepting of School Insurance

6. School Insurance plans require verification that the patient is not covered under any other insurance plan. Complete Insurance Statement Form if the family does not have any other insurance and have parent/guardian sign.

Accepting of Workmen's Compensation

7. DUE TO STATE REGULATIONS BY THE TEXAS WORKERS' COMPENSATION COMMISSION-PROVIDERS MUST RECEIVE TRAINING TO TREAT WORKERS' COMPENSATION CLIENTS. THEREFORE, **STRHS, INC. WILL NOT ACCEPT WORKERS' COMPENSATION.** PATIENTS WITH A WORK RELATED INJURY MUST BE INFORMED THEY WILL BE RESPONSIBLE FOR ALL PAYMENTS, IF THEY CHOOSE TO RECEIVE SERVICES AT OUR CLINICS.

Accepting of Private Insurance or Employer Payment for Department of Transportation Physicals (DOT)

8. STRHS, Inc. *is not* certified to provide DOT physicals. We cannot provide this service.

South Texas Rural Health Services, Inc.

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

I acknowledge I have received the Notice of Privacy Practices of
South Texas Rural Health Services, Inc.

Name: _____
[Print Name of Patient/Patient Representative]

By: _____ Date: _____
[Signature of Patient/Patient Representative]

_____
[If Signed by Patient Representative,
Indicate Relationship to Patient]

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

_____

_____

_____

_____

_____

_____

By: _____ Date: _____
[Signature of Center Representative]

Name: _____
[Print Name of Center Representative]

Title: _____
[Print Title of Center Representative]

SOUTH TEXAS RURAL HEALTH SERVICES, INC.
INFORMED CONSENT TO MEDICAL TELEHEALTH SERVICES

Telehealth allows my provider to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in medical services via the internet (hereinafter referred to as Telehealth) with South Texas Rural Health Services, Inc.

Patient Name: _____ MR/Person#: _____

I understand I have the following rights under this agreement:

I understand that telemedicine is the use of electronic information and community technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to South Texas Rural Health Services, Inc. providing health care services to me via telehealth.

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person counseling services. Any information disclosed by me during the course of my treatment, therefore, is generally confidential.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that my communication with my provider could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person that if my provider believes I would be better served by in-person treatment, I will be scheduled for in-person services.

I have read and understand the information provided above. I have the right to discuss any of this information with my provider and to have any questions I may have regarding my treatment answered to my satisfaction.
I understand that I can withdraw my consent to Telehealth communications by providing written notification to South Texas Rural Health Services, Inc.

My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Authorized Signature for Client **Date**