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

Self-Declaration of Employment and Income

Declaration of Employment: This section is to be filled out and signed by the patient or parent/guardian if the patient is a minor.

I certifiy that I am unemployed or have no income documentation.

If you receive income from any source, document where you receive income from:

Check how you receive your income;

weekly ___

biweekly ___

monthly ___

annual ___

I declare my family income was $_____. The source of my income is_____

_____.

I certify that the information that I provided is correct and I authorize South Texas Rural Health Services, Inc. to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount for health services.

Applicant Signature:_____

Date:_____

Comments:

Financial Support Form

Declaration of patient/client support by another person.

Name of patient/client receiving support:

_____

I _____ provide support in the amount of
(print name of person providing support)

_____ every _____.
(dollar amount) (week/month)

My phone number is _____.

_____ _____
(signature of person providing support) Date

South Texas Rural Health Services, Inc.
Mental Health Program
Consent for Treatment on Behalf of a Minor*

Name of minor patient: _____ **Date of Birth** _____ /_____ /_____

** A minor is an individual who is under 18 years of age who is not and has not been married or had the disabilities of minority removed by the court.*

I am authorized to consent on behalf of the above minor as I am the minor's
□ parent or □_____.
State relationship to minor that grants authority

_____ Please initial if you want Behavioral Health Counseling Services for your Child.

_____ Please initial if you want Substance Abuse Services for your Child.

_____ Please initial if you give us permission to counsel your child at his or her assigned school campus.

I _____ hereby and voluntarily consent to authorize the
Print the name of parent or legally authorized person
Behavioral Health Provider at their service locations to provide Behavioral Health Services to the above minor. Behavioral Health Care Services may include routine physical and mental health assessments, diagnostic evaluation & treatment, referral to STRHS Medical Department if additional assessments are needed, and psychotheraphy and/or psychological testing, if available. **I understand that there are no guarantees being made to me concerning the results of the treatment or the effectivness of any services prescribed for the above minor.**

(If you have any questions about the following statements, please discuss them with your counselor)

1. I understand that **NO** information about the counseling that occurs will be released outside of South Texas Rural Health Services, Inc. (STRHS) without my **WRITTEN** authorization. I further understand that there are limits to this confidentiality agreement, and they include the following:

    A. In cases where a counselor has reason to believe that a person may be in imminent danger of harming her/himself or others (e.g., suicide or homicide), that counselor must take appropriate action to prevent that harm. Parents/guardians/conservators of minors under the age of 18 will be notified when imminent danger is believed to exist.
    B. The state of Texas mandates that any person who knows or suspects that a child, an elderly person, or a disabled person is in danger of being physically, emotionally, or sexually abused must report such abuse or suspected abuse to the proper authorities. Counselors are also required to report suspected sexual exploitation of counseling clients by counselors.
    C. In Texas, confidentiality does not extend to criminal proceedings or to legitimate subpoenas from a judge in civil proceedings. If a court subpoenas counseling records, STRHS is required to provide the information requested.
    D. In Texas, parents (or legal guardians) are legally allowed to have access to their child's records until the child reaches their 18th birthday.

Please Initial Below

_____ I understand the limits of confidentiality stated above and accept them as part of the conditions of receiving mental health or behavioral health services from STRHS.

I have received the ***Patient and Center Rights and Responsibilities*** and the ***Notice of Patients Privacy Rights*** and understand those documents.

I certify that I fully understand this consent for treatment and the minor's rights concerning these issues.

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

I have been given an opportunity to ask questions about the services to be provided by this Center and I believe that I have sufficient information to give this consent.

□ I hereby delegate authority to consent to treatment for the above minor to

*(Print name) _____ for the period of ____/____/____ through ____/____/____ .

**The individual delegated to give authority and receive authority for consent of treatment to minors must be 18 years of age or older.*

_____	_____
Signature of Parent or Legal guardian	Witness
_____	_____
Print Name	Print Name
_____	_____
Date Time	Date Time

*Translated into _____/Read to person consenting by:

_____	_____	_____	
Signature	Print Name	Date	Time

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: _____ ____/____/____
Date

Name: _____
[Print Name]

South Texas Rural Health Services, Inc.

NOTICE OF PRIVACY PRACTICES

Effective : April 14, 2003

To our Patients:

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact the Center's Privacy Officer at: (830) 879-3047.

WHO WILL FOLLOW THIS NOTICE

This Notice of Privacy Practices ("Notice") describes South Texas Rural Health Services, Inc. (the "Center") privacy practices and that of all Staff, employees, contractors, healthcare providers (e.g., physicians, nurses and other licensed or certified personnel), volunteers, front desk, billing and administrative personnel, who have a need to use your health information to perform their job. It also applies to any individuals authorized to enter information into your Center record.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive at the Center. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the Center, whether made by Center personnel or other healthcare providers. Your other healthcare providers may have different policies or Notices regarding their use and disclosure of your health information created at their location.

We are required by law to:

- Maintain the privacy of health information that identifies you (with certain exceptions);
- Give you this Notice of our legal duties and privacy practices with respect to health information we collect and maintain about you; and
- Follow the terms of this Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose health information. Following each category is an explanation. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

DISCLOSURE AT YOUR REQUEST. We may disclose health information when requested by you. This disclosure at your request may require a written authorization by you.

FOR TREATMENT. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, students, or other Center personnel who are involved in taking care of you at the Center. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Additionally, the doctor may need to tell the social worker if you have diabetes so we can arrange for appropriate follow up. Different areas of the Center also may share health information about you in order to coordinate the different things you need, such as medications, lab work and x-rays. We also may disclose health information about you to people outside the Center who may be involved in your healthcare after you leave the Center, such as nurses, social workers, family members, or clergy.

FOR PAYMENT. We may use and disclose health information about you so that the treatment and services you receive at the Center may be billed to and payment may be collected from you, an insurance company or a third party such as Workers Compensation. For example, we may need to give your health plan information about a procedure you received at the Center so your health plan will pay us or reimburse you for the procedure or encounter. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

FOR HEALTH CARE OPERATIONS. We may use and disclose health information about you for our health care operations activities. These uses and disclosures are necessary to operate the Center efficiently and make sure that all of our patients receive quality care. For example, we may use health information to review the safety and the quality our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine and analyze health information about many Center patients to decide what additional services the Center should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, students, volunteers and other Center personnel for review and learning purposes. Additionally, we may combine the health information we have with health information from other Centers to compare how we are doing and to see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific patients are.

ADDITIONAL USES AND DISCLOSURES OF HEALTH INFORMATION INCLUDE:

APPOINTMENT AND PATIENT RECALL REMINDERS. We may use and disclose your health information to contact you to remind you regarding appointments or for health care that you are to receive.

SIGN IN SHEET. We may use and disclose health information about you by having you sign in when you arrive at the Center. We may also call out your name when you are ready to be seen.

TREATMENT ALTERNATIVES. We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

AS REQUIRED BY LAW. We will disclose health information about you when required to do so by federal, state or local laws or regulations.

BUSINESS ASSOCIATES. Some of our functions are accomplished through contracted services provided by "Business Associates." A "Business Associate" may include any individual or entity that receives your health information from us in the course of performing services for the Center. Such services may include, without limitation, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

DIRECTORY. We may include certain limited information about you in the Center directory while you are a patient at the Center. This information may include your name, address and general condition. Unless there is a specific written request from you to the contrary, this directory information may also be released to people who ask for you by name.

DISASTER RELIEF. We may disclose information about you to an entity assisting in disaster relief so that your family can be notified about your condition, status and location.

FUNDRAISING. We may use information about you in an effort to raise money for the Center and its operations. We may disclose health information to a foundation related to the Center so that the foundation may contact you in raising money for the Center. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the Center. If you do not want the Center to contact you for fundraising efforts, you must notify the Center's Chief Executive Officer Alfredo Zamora Jr. at: (830) 879-5689 and in writing at: **South Texas Rural Health Services, Inc. PO Box 599 Cotulla, Texas 78014**

HEALTH-RELATED PRODUCTS AND SERVICES. We may use and disclose health information to tell you about our health-related products or services that may be of interest to you.

FAMILY, FRIENDS, OR OTHER INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE. We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another individual involved in or responsible for your health care about your location at the Center, your general condition, or in the event of your death. We may also disclose information to someone who helps arrange for payment for your care. If you are able and available to agree or to object, we will give you the opportunity to agree or object prior to making these disclosures, although we may disclose this information in the case

of a disaster even over your objection if we believe it is necessary to respond to the disaster or emergency situation. If you are unable or unavailable to agree or object, we will use our best judgment in any communication with your family, personal representative, and other involved individuals.

RESEARCH. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. However, we may also disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the Center.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, we may notify emergency response personnel about a possible exposure to Acquired Immune Deficiency Syndrome ("AIDS") and/or the Human Immunodeficiency Virus ("HIV"). Any such disclosure, however, would only be to the extent required or permitted by federal, state or local laws and regulations.

CHANGE OF OWNERSHIP. In the event that the Center is sold or merged with another organization, your health information/medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another Center, medical group, physician or other healthcare provider.

SPECIAL SITUATIONS

FUNERAL DIRECTORS, CORONERS AND MEDICAL EXAMINERS. We may disclose your health information to funeral directors as necessary to carry out their duties. We may also disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

HEALTH OVERSIGHT ACTIVITIES. We may disclose your health information to a health oversight agency for activities authorized by federal, state or local laws and regulations. These oversight activities include, for example, audits, investigations, inspections, licensure, illegal conduct, or compliance with other laws and regulations. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

INMATES. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the institution or law enforcement official, if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

LAW ENFORCEMENT. We may release your health information if asked to do so by a law enforcement official in the following circumstances: (a) In response to a court order, subpoena, warrant, summons or similar process; (b) To identify or locate a suspect fugitive, material witness, or missing person; (c) About the victim of a crime, if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) About a death we believe may be the result of criminal conduct; (e) About criminal conduct at the Center; and/or (f) In emergency situations to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

LAWSUITS AND DISPUTES. If you are involved in a lawsuit or a dispute, we may disclose your health information to the extent expressly authorized by a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request (which may include written notice to you) and you have not objected, or to obtain an order protecting the information requested.

MILITARY AND VETERANS. If you are a member of the armed forces, we may release health information about you as required by military authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES. We may release health information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

ORGAN AND TISSUE PROCUREMENT ORGANIZATIONS. If you are an organ donor, we may disclose health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS. We may disclose health information about you to authorize federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

PUBLIC HEALTH REPORTING. We may disclose health information about you for public health activities. We will only make this disclosure if you agree or when required or authorized by law. These activities generally include the following: (a) To prevent or control disease, injury or disability; (b) To report births and deaths; (c) To report the abuse or neglect of children, elders and dependent adults; (d) To report reactions to medications or problems with products; (e) To notify people of recalls of products they may be using; and (f) To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE. We may disclose your health information to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure when required or authorized by law.

WORKERS' COMPENSATION. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

SECURITY CLEARANCES. We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the officials in the Department of State who need access to that information for these purposes.

MULTIDISCIPLINARY PERSONNEL TEAMS. We may disclose health information to a state or local government agency or a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

SPECIAL CATEGORIES OF HEALTH INFORMATION. In some circumstances, your health information may be subject to additional restrictions that may limit or preclude some uses or disclosures described in this Notice or Privacy Practices. For example, there are special restrictions on the use and/or disclosure of certain categories of health information. For example, (1) AIDS treatment information and HIV tests results; (2) treatment for mental health conditions and psychotherapy notes; (3) alcohol, drug abuse and chemical dependency treatment information; and/or (4) genetic information, are all subject to special restrictions. In addition, Government health benefit programs, such as Medicare or Medicaid, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

YOUR PRIVACY RIGHTS

You have the following rights regarding health information we maintain about you:

RIGHT TO INSPECT AND COPY. You have the right to inspect and copy health information that may be used to make decisions about your care. Usually this includes medical and billing records, but may not include some mental health information. If you request a copy of your health information that may be used to make decisions about your care, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to:

South Texas Rural Health Services, Inc.

PO Box 599

Cotulla, Texas 78014]

We may deny your request to inspect and copy in specific circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who denied your request. The Center will comply with the outcome of the review.

RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the health information the Center uses or discloses about you for treatment, payment or health care operations. You can also request a restriction or limitation on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

WE RESERVE THE RIGHT TO ACCEPT OR REJECT YOUR REQUEST. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We will notify you if we do not agree to a requested restriction.

To request restrictions, you must submit a written request to the Center at the above address. In your request, you must state: (1) what information you want to limit; (2) whether you want to limit its use, disclosure or both; and (3) to whom you want the limits to apply; for example, no disclosures to your spouse.

RIGHT TO AMEND. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to your health information for as long as the information is kept by or for the Center. You must make your request to amend your health information, in writing, and submit it to the Center at the above address. You must include a reason that supports your request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
2. Is not part of the health information kept by or for the Center;
3. Is not part or the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

The law permits us to deny your request for an amendment if it is not in writing or does not include a reason to support the request.

Even if the Center denies your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

REQUEST AN ACCOUNTING OF DISCLOSURES. You have the right to request an "accounting of disclosures." Such an accounting is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations (as those functions are described above) and with other expectations pursuant to law. To request this list or accounting of disclosures, you must submit your request in writing to the Center at the above address. Your request must state a time period that may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You must make your request for confidential communications in writing to the Center at the address noted above. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE. You have the right to receive a paper copy of this Notice. You may request a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effective for all health information we have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Center. The Notice will contain on the first page, in the top right-hand corner, the effective date. If we amend this Notice, we will offer you a copy of the current Notice in effect. You may request a copy of the current Notice each time that you visit the Center for services or by calling the Center and requesting that the current Notice be sent to you in the mail.

FOR MORE INFORMATION, TO FILE A COMPLAINT OR TO REPORT A PROBLEM

If you believe that your privacy rights have been violated, you may file a complaint with the Center and/or with the Secretary of the federal Department of Health and Human Services. All complaints must be submitted in writing. To file a complaint with the Center, send a written complaint to the Center's Privacy Officer at:

South Texas Rural Health Services,Inc.

PO Box 599

Cotulla, Texas 78014

Attention: **Alfredo Zamora Jr., Chief Executive Officer**

If you would like to discuss a problem without submitting a formal complaint, you may contact the Privacy Manager by telephone at (830) 879-3047 ; or by facsimile at (830)879-2940 ; or via e-mail at: co.strhs@tachc.org In addition, you may contact the CEO by telephone at (830)879-3047 or by facsimile at (830) 879-2940 ; or via e-mail at: ceo.strhs@tachc.org

A complaint may be filed with the Secretary of the federal Department of Health and Human Services at:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building 200
Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will stop the uses and disclosures allowed by that permission, except to the extent that we have already acted in reliance on your permission. For example, we are unable to take back any disclosures we have already made with your permission.

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.
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

SCHOOL INSURANCE STATEMENT FORM

I _____, parent/guardian confirm there is no other insurance policy
(Print Parent/Guardian Name)

covering _____.
(Print Patient Name)

SOUTH TEXAS RURAL HEALTH SERVICES, INC.

NOTICE OF PRIVACY PRACTICES
PSYCHIATRY ADDENDUM

Effective Date: April 14, 2003

THIS ADDENDUM NOTICE DESCRIBES HOW PSYCHIATRIC OR MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS ADDENDUM NOTICE IS PART OF THE "NOTICE OF PRIVACY PRACTICES" THAT APPLIES TO YOUR OTHER HEALTH INFORMATION. PLEASE REVIEW THIS ADDENDUM AND THE NOTICE OF PRIVACY PRACTICES DOCUMENT CAREFULLY.

If you have any questions about this Notice, please contact the Center's Privacy Manager at: (830) 879 - 2502 ; or the Center's Executive Director at: at: (830) 879 - 3047 .

CONFIDENTIALITY OF PSYCHIATRIC OR MENTAL HEALTH RECORDS

The confidentiality of your psychiatric or mental health records maintained by the Center gets special protection under federal and state laws. We may, however, disclose psychiatric or mental health information that identifies you without your authorization in the following circumstances:

DISCLOSURE AT YOUR REQUEST. We may disclose health information when requested by you. This disclosure at your request may require a written authorization by you.

FOR TREATMENT. We may use your psychiatric/mental health information to provide you with medical treatment or services. We may disclose your psychiatric information to health care professionals outside this facility only if they are responsible for your physical or mental health.

FOR PAYMENT. We may use or disclose your psychiatric/mental health information to substantiate or collect on a claim for mental health treatment or services you receive at the Center.

FOR HEALTH CARE OPERATIONS. We may use and disclose psychiatric/mental health information about you for our health care operations activities. These uses and disclosures are necessary to operate the Center efficiently and make sure that all of our patients receive quality care.

ADDITIONAL USES AND DISCLOSURES OF MENTAL HEALTH INFORMATION INCLUDE:

AS REQUIRED BY LAW. We will disclose health information about you when required to do so by federal, state or local laws or regulations.

FOR LEGAL PROCEEDINGS AND DISPUTES. If you are involved in a judicial or administrative legal proceeding (lawsuit or a dispute), we may disclose psychiatric/mental health information about you in response to a court or administrative order or when such disclosure is otherwise required or permitted by law. For example, we may disclose psychiatric or mental health information to courts, attorneys and court employees in the course of conservatorship, and certain other judicial or administrative proceedings. We may also disclose mental health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in

the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

FOR RESEARCH. We may disclose your psychiatric/mental health information to researchers who request it for approved medical research projects; however, such disclosures must be cleared through a special approval process before any information is disclosed to the researchers who will be required to safeguard the information they receive.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, we may notify emergency response personnel about a possible exposure to Acquired Immune Deficiency Syndrome ("AIDS") and/or the Human Immunodeficiency Virus ("HIV"). Any such disclosure, however, would only be to the extent required or permitted by federal, state or local laws and regulations.

TO LAW ENFORCEMENT. We may disclose your psychiatric/mental health information to law enforcement personnel in limited and specific circumstances. For example, we may disclose psychiatric information to law enforcement if your provider determines that there is a probability of imminent physical injury by a patient (to himself/herself or to another person). In addition, we may disclose your psychiatric/mental health information if a crime has been committed by a patient at the Center.

TO GOVERNMENT AGENCIES. We may disclose your psychiatric/mental health information to notify the appropriate government agency when required or authorized by law (for example, if we believe that a patient has been the victim of abuse or neglect).

TO HEALTHCARE OVERSIGHT AGENCIES. We may disclose your psychiatric/mental health information to healthcare oversight agencies to ensure that we are meeting the standards of care and services and that we are complying with the applicable laws and regulations. We will only make this disclosure when required or authorized by law.

SPECIAL CATEGORIES OF HEALTH INFORMATION. In some circumstances, your health information may be subject to additional restrictions that may limit or preclude some uses or disclosures described in this Notice or Privacy Practices. For example, there are special restrictions on the use and/or disclosure of certain categories of health information. For example, (1) AIDS treatment information and HIV tests results; (2) treatment for mental health conditions and psychotherapy notes (*see* discussion, below); (3) alcohol, drug abuse and chemical dependency treatment information; and/or (4) genetic information, are all subject to special restrictions. In addition, Government health benefit programs, such as Medicare or Medicaid, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

PSYCHOTHERAPY NOTES. Psychotherapy notes are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes exclude: (a) medication prescription and monitoring; (b) counseling session start and stop times; (c) the modalities and frequencies of treatment furnished; (d) results of

clinical tests; and (e) any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.1

We may use or disclose your psychotherapy notes, for treatment, payment or healthcare operations, or:

1. for use by the originator of the notes;
2. in supervised mental health training programs for students, trainees, or practitioners;
3. by the covered entity to defend a legal action or other proceeding brought by the individual;
4. to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
5. for the health oversight of the originator of the psychotherapy note;
6. for use or disclosure to coroner or medical examiner to report a patient's death, and information related to the diagnosis and treatment of the patient's physical condition;
7. for use or disclosure necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
8. for use or disclosure to the Secretary of the U.S. Department of Health and Human Services ("DHHS") in the course of an investigation; and/or
9. as required by law.

Generally, we will not tell anyone outside the Center that you are being treated by the Center for a psychiatric or mental health issue.

Other uses and disclosures of your psychiatric or mental health information not covered by this Notice of Privacy Practices, Psychiatric Addendum or the laws that apply to us will be made only with your written authorization.

Please see the general Notice of Privacy Practices for information on revoking an Authorization for the Use or Disclosure of Health Information. Your rights regarding your health information outlined in the general Notice of Privacy Practices also apply to your psychiatric/ mental health information.

1 45 C.F.R. §164.501.

SOUTH TEXAS RURAL HEALTH SERVICES, INC.

NOTICE OF PRIVACY PRACTICES
PSYCHIATRY ADDENDUM

PATIENT ACKNOWLEDGEMENT

I acknowledge I have received the Notice of Privacy Practices, Psychiatry Addendum of *South Texas Rural HealthServices, Inc.*

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

By: _____
[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: _____
[Title of Center Representative]

Distribution: Original – Medical Record; Copy – Patient/Patient Representative

South Texas Rural Health Services, Inc.
Behavioral Health Program

Confidentiality Regulations

General Information

Information regarding your health care, including payment for health care, is protected by two Federal laws: The Health Insurance Portability and Accountability Act of 1996(HIPPA), 42 USC&1320d et seq., 45 CFR Parts 160&164 and the Confidentiality Law, 42 USC &290dd-2, 42 CFR, Part 2. Under these laws, South Texas Rural Health Services may not inform a person outside of STRHS that you receive services, nor may STRHS disclose any information identifying you as an alcohol or drug abuser. STRHS may not disclose any other protected information except as permitted by Federal law.

No information regarding you, your progress, and/or any other issues involving you and this program will be made available to anyone other than yourself at any time. Any information requested by another source, or agency will have to provide the request in writing followed by your written consent. Evan then, only the information that you request will be released. Releases of information for referral sources, emergency contacts and any insurance companies may be needed upon admission to South Texas Rural Health Services, Inc. Behavioral Health Program.

Federal law permits STRHS to disclose information without your written permission:

1. When client threatens suicide;
2. For research audit or evaluations;
3. To report a crime committed on STRHS premises or against STRHS personnel;
4. To medical personnel in a medical emergency;
5. To appropriate authorities to report child abuse or neglect;
6. As allowed by a special court order.

Your Rights:

Under HIPPA you have the right to request restrictions on certain uses and disclosures of your health information. STRHS is not required to agree to any restriction you request, but if we do agree then we are bound by that agreement and may not disclose any information which you have restricted except as necessary in a medical emergency.

Complaints and Reporting Violations:

You may complain to STRHS and/ or The Texas Department of State Health Services. You will not be retaliated against for filling such a complaint.

Contact

Mr. Alfredo Zamora, Jr. CEO, 611 Thompson Drive Street Cotulla, Tx. 78014
(830) 879-3047 or Fax (830) 879-2940

Effective Date

I hereby acknowledge that I have received a copy of this notice on this date and it has been explained in my primary language, and I understand the issues of confidentiality and have been afforded the opportunity to ask questions and/or have been explained anything that was not clear.
I now comprehend the issues of confidentiality, its limitations and how it pertains to this agency.

Client Signature Date

Counselor Signature Date

South Texas Rural Health Services, Inc.
Consent For Release of Confidential Information

I_____authorize:
(Print Name) (Date of Birth)

South Texas Rural Health Services & Their Staff Members
To Communicate With:

_____
(Name of Agency to be disclosed to)

The Following Information:

_____
(Nature of information)

The purpose of the disclosure authorized herein is to:

_____

I understand that my records are protected under the Federal Regulations governing Confidentially of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act., HIPPA, of 1996 and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except, to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year from date of signing or on date specified below. If there is a difference between CFR 42, Part 2 and HIPPA, whichever regulation is stricter will apply.

A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I further understand that when information is disclosed, this information is protected by Federal Law and may not be re-disclosed except with my consent or under other authorization (42 CFR, Part 2.32). Disclosed information may be verbal or in writing and the prohibition on re-disclosure pertains to both.

My consent expires **One Year** from the date of my signature or on the date specified:

Date:_____ _____
(Signature Of Participant)