Healing Hands Ministries

Hope for the spirit. Health for the body!

8515 Greenville Avenue, Suite N-114 Dallas, TX 75234
(214) 221-0855

ENGLISH ADULTS

ENROLLMENT REQUIREMENTS FOR SLIDING FEE PATIENTS

1. Proof of Household Income from everyone in the household who works

- Most recent **pay check stubs**, **(*please bring at least 3-4 paycheck stubs) (Must be dated within 30 days of registration)*** *OR*
- **Previous year tax return**, *OR*
- **Employer statement of income**, which states gross income and frequency of pay. This letter must be **DATED, SIGNED** and include a **TELEPHONE NUMBER**.

Award Letter received from **(GOVERNMENT ASSISTANCE)** only if this applies to you or anyone in your household:

- **Food Stamps**
- **Child Support**
- **Social Security/ Disability**
- **Unemployment**
- **SSI**
- **Public Housing**
- **TANF**

2. Valid Picture ID and **Insurance Card** if any

All information provided must be current, dated within the last 30 days.
Please make sure to bring all required documents at time of registration.
All registrations please go to Suite #114 on the first floor

Registration Hours:
Monday – Friday
7:30 AM – 4:30 PM

You will need to recertify every 12 months from when you last renewed or registered.
To recertify you will be required to bring in the updated documents mentioned above.

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Acct #: _____ Date: _____ EMP initials: _____

Registration Form

Date: _____/_____/_____ Referred by: _____

Name: _____
Last **First** **Middle Name**

Male: _____Female: _____ SS#:_____/_____/_____Married: _____ Single: _____ Language: _____

Date of birth: _____/_____/_____Ethnicity: Hispanic, Not Hispanic Race: Asian, Black or African American, White
Month Day Year

Current Address: _____ Apt # _____

City: _____State: _____Zip Code: _____

Home Phone (_____) _____ Cell (_____) _____

Employer: _____ Work Phone (_____) _____

Email Address: _____ Preferred Contact Method: Hm, Wk, Cell, Email
Is it ok to leave a detailed voicemail regarding medical results? Yes:_____No:_____

In case of an emergency, contact:
Name_____Phone: _____

Relationship to Patient: _____

Do you have medical insurance? Medicaid or Medicare? Yes__ No __ If Yes, What do you have? _____

Insured Name _____ Date of Birth _____Relationship to insured_____
****

Complete this section if you are enrolling for the Healing Hands Ministries Sliding Fee Program

#of people living in your household: _____
List Name(s: _____

Do you receive federal or state assistance? Yes _____No _____

If you receive assistance, please check what you receive:
Food Stamps __ TANF __ Public Housing __ Child Support __ Social Security __ Disability ___ Unemployment ___

Does your job pay you: Weekly____Bi-Weekly ____ Semi-monthly ____ Monthly ____ Annually ___

HHM Administrated 1.1.07, Revised 2.1.18

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Healing Hands Ministries Partnership in Care Agreement

Healing Hands Ministries is pleased to be a partner with you in your healthcare. We know that managing your health includes you being involved. You, as a patient, are in control of your health. The choices that you make every day have an impact on your health. Your diet, exercise and other decisions you make impact your health as much as or more than any physician.

We are committed to educating you about your health and working with you. Having better information and taking an active role can help you make healthier decisions. We encourage you to ask questions and share ideas with our healthcare team.

We will encourage you to take an active role in your healthcare by making the following wise choices for each visit that you have:

1. Always bring all medications that you are taking with you to each visit. (prescription drugs, over-the-counter medicines, vitamins, and herbal remedies and supplements)
2. Make a list in advance of things that you may want to discuss at your appointment.
3. Be sure to make transportation plans in advance and arrive 20 minutes early to each appointment.
4. Be sure to ask questions if you don't understand something.
5. Follow the plan of treatment recommended by your physician.
6. Take all medications as directed.
7. Respond to all communications from the clinic.
8. Please review the clinic rules, be compliant, and keep a copy of them with your records.
9. Inform of any address, telephone number(s), and income or insurance changes.
10. **24 hours in advance notice if unable to keep appointment. Failure to keep the appointment or give notice 24 hours in advance will result in a $10 no-show fee that will be billed.**
11. Arriving late for an appointment will result in being rescheduled for the next available time.
12. **Patients that fail to keep or cancel their appointments three times in a 12-month period or five times for Children under the age 18 may be prevented from scheduling future appointments for a period of six months and will be seen on a same-day or walk-in basis only.**
13. I understand my treatment may be unsuccessful if I fail to follow the physician's orders and referrals.
14. There is no cell phone usage or any charging of cell phones in the clinic.
15. HHM reserves the right to refuse services to patients that have conducted themselves in a manner that is considered inappropriate. (Uncooperative, verbally abusive, intoxicated, etc.)

Patient: _____ _____
Signature **Date**

Screener: _____ _____
Signature **Date**

Patient name: _____
Printed

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HIPAA Authorization Release Form

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, _____, an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

□ **I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to: ** Read this to its entirety****

Spouse_____ Phone Number _____
Sons/ Daughters _____ Phone Number _____
Parent(s) _____ Phone Number _____
Other_____ Phone Number _____

□ **Information is not to be released to anyone.**

Complete the following by indicating those items that you want you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

□ **All health information** □ History/Physical Exam □ Past/Present Medications □ Lab Results
□ Physician's orders □ Patient Allergies □ Operation Reports □ Consultation Reports
□ Progress Notes □ Discharge Summary □ Diagnostic Test Reports □ EKG/Cardiology Reports
□ Pathology Reports □ Billing Information □ Radiology Reports & Images □ Other_____
□ Mental Health Records (excluding psychotherapy notes) □ Genetic Information (including Genetic Test Results)
□ Drug, Alcohol, or Substance Abuse Records □ HIV/AIDS Test Results/Treatment

Signature_____**Date**_____
Signature of Individual or Individual's Legally Authorized Representative

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TERMINATION

This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

RE-DISCLOSURE

By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person or persons whose name(s) is/are written above, and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require my authorized persons to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

INSTRUCTIONS TO MY AUTHORIZED PERSONS

My authorized persons shall have the right to bring a legal action in any applicable form against any covered entity that refuses to recognize and accept this authorization for the purposes I have expressed. Additionally, my authorized persons are authorized to sign any documents that the authorized persons deem appropriate to obtain the protected medical information.

VALID DOCUMENT

A copy or facsimile of this original authorization shall be accepted as though it were an original document. WAIVER AND RELEASE I hereby release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my authorized persons.

Signed on the _____ day of _____, 20_____.

_____

Signature of Individual or Individual's Legally Authorized Representative

_____

Print Name

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Consent for Treatment and Payment

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

Name of person giving consent if different from Patient:

[Print Name]: _____

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

I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services to me at the center's service locations. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

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 are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent, or until the center changes its services and asks me to complete a new consent form.

I understand that payment for medical service is due on the day of the visit. Payment may be made by cash or credit card. Insurance/Financial arrangements should be made with the center prior to any service.

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Consent Provisions

My signature on this form indicates that:

1. **I certify that I have read and fully understand the foregoing consent and that the facts indicated are true.**
2. **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.**
3. **I understand that midlevel providers (Physician Assistants, Family Nurse Practitioners and Trained Medical Assistants) may be involved in my treatment and I consent thereto.**
4. **I understand that I may be asked to sign a separate informed consent form for certain Treatment(s).**
5. **I hereby voluntarily give my consent to Treatment to the Center.**
6. **I the undersigned authorize the center to release any information acquired in the course of my treatment to my insurance company (s), another physician or medical facility (s). I hereby agree that I am responsible for said fee (s). I authorize payment directly to and assign to the center, if any,**

_____ _____

Signature of Patient/Legal Representative **Date**

_____

Print Name **Relationship to Patient**

_____

Signature of Witness, if not patient **Print Name** **Date**

Interpreter/Translator to complete when applicable:

I have accurately and completely read/translated 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.
Interpreted/Translated

By: _____

Signature of Interpreter/Translator

_____

Print Name of Interpreter/Translator: **Date**

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Birth Sex/ Sexual Orientation/ Gender Identity

Please check the box that applies to you. This information remains private and confidential at all times.

Birth Sex

- ☐ Male
- ☐ Female
- ☐ Unknown

Sexual Orientation

- ☐ Lesbian, gay, homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Do not know
- ☐ Choose not to disclose
- ☐ Something else, please describe_____

Gender Identity

- ☐ Male
- ☐ Female
- ☐ Female-to-male (FTM)/ Transgender Male/ Trans Man
- ☐ Male-to-Female (MTF)/ Transgender Female/ Trans Woman
- ☐ Gender queer, neither exclusively male or female
- ☐ Choose not to disclose
- ☐ Additional gender category or other, please specify _____