PATIENT APPLICATION

Today's Date:

Date of Birth

Male Female

Social Security#

Married Single Divorced Widow

Name

Address

City State Zip Code

Home phone Cell

Email:

Race/Ethnicity Hispanic Non-Hispanic

White Asian African American Middle Eastern American Indian Other

Number of people living in your household: Adults: Children under 18:

	Name	Relationship	Do they work (yes or no)
List all members: Of household:			

In case of emergency contact: Name Phone

Do you receive federal or state assistance? Yes No Which?

Do you have medical insurance, Medicaid or Medicare? Yes No Which?

Parent/Guardian

Name Relation

Address

City State Zip Code Phone

Notice

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

*Signature_* *Date*

Upload document to: Admin: Signed Forms & letters (include proof of residency and photo ID)

Patient Consent for Release of Protected Health Information (PHI)

Many of our patients allow family members such as their spouse, parents, or others to call &request test results/procedures, appointments & prescription/sample pick up. Under the requirements of HIPPA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your protected health information (PHI) release to anyone other than yourself, you must complete this form. This form will expire by written notification from you ONLY.

I, ______________________, give my consent to the Community Health Clinic to release protected health information (PHI) such as; **labs. medications. orescriptions, samples, aopointments. provider's notes, etc.** to the following individuals in person or via telephone.

Name	Relationship	Phone # (if different from patient)
Name	Relationship	Phone # (if different from patient)
Name	Relationship	Phone# (if different from patient)

Authorization to leave personal health information by alternate means

Please check all that apply: **(detailed messages may include lab/test results)**

May leave detailed message on voicemail at home#:

May leave detailed message on mobile phone#:

May leave detailed message on voicemail at work#:

May leave information with spouse (name):

May leave information with other family member (name):

Do NOT leave any detailed message on any phone.

May leave information **ONLY** about appointment reminders.

I agree to receive text message appointment reminders and other health related information.

______________________ ______________________

Patient Name (please print) Relationship

______________________ ______________________

Patient Name (signature) Date

Upload document to: Admin: Release of Personal Health Information

Patient Agreement

Community Health Clinic is a non-governmental, non-profit agency which is designated to provide health care to those families in McKinney and designated area who have no other means of obtaining health care. Our clinic is staffed by volunteer doctors and nurses who are not paid for their services.

To better serve you, we ask you for your cooperation in following the policies listed below. If you are unable to follow these guidelines, or find them unacceptable, another health care provider may be better able to meet your needs.

I understand and agree to do the following:

1. I will inform CHC if my address, telephone number(s), income or insurance changes within 30 days of any change.
2. I will give CHC 24 hours' notice if I will be unable to keep my appointment.
3. Patients must arrive 15 minutes prior to their appointment time. Arriving late for an appointment, will result in being rescheduled for the next available time.
4. If I miss 3 appointments without notifying CHC, I understand that I may no longer be able to receive services at CHC.
5. I do authorize any health care professional associated with CHC to disclose any personal health information to other health care professionals, when medically necessary.
6. I do authorize the administrative staff of CHC to disclose my registration and screening information for the purpose of obtaining free services at another facility.
7. I understand that I am solely responsible for the following through on testing and treatment ordered by the providers at CHC. I understand that if I fail to follow the provider's orders my treatment may be unsuccessful.
8. I understand that I may be liable for any costs associated with imaging services.
9. I understand that if I am uncooperative, verbally abusive, intoxicated or behave in an inappropriate manner, I may not be eligible for services at CHC and may be dismissed from CHC immediately.
10. I will keep my children with me at all times.

I have received a full explanation of CHC services and I understand and agree to all of the above. I understand I can be dismissed from the clinic as a patient, if I have given wrong information, misleading information, or if I fail to follow the policies above.

Patient signature Date

Privacy:

You have a right to have your interviews, examinations and treatment in surroundings that provide reasonable privacy. Your medical records are also private. Only legally authorized persons may see your records unless you request in writing for us to show them to someone else. A complete discussion of your privacy rights is attached as "HIPAA Notice of Privacy Practices." By signing this document you are indicating that you have received this Notice. The Notice details the various rights granted to you by the Health Insurance Portability and Accountability Act (HIPAA).

Patient signature Date

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AUTHORIZATION TO USE AND DISCLOSE CONFIDENTIAL HEALTH INFORMATION

Community Health Clinic is an independent 501(()3 charity clinic that provides health care services to individuals residing in Collin County to better coordinate health care provided to uninsured individuals, to overcome barriers to health care faced by uninsured individuals, and to implement appropriate disease management systems to improve the health status of uninsured individual patients. Community Health Clinic may need to use and share among themselves confidential health information. This use and disclosure will require an authorization by each uninsured individual (or individual's representative) who desires to participate. If you agree to authorize the use and disclosure of your confidential health information as set forth in this Form, please sign below.

I, , authorize CHC and healthcare providers affiliated with CHC to use, release, and disclose my confidential healthcare information for the purposes set forth above, to their employees, and healthcare providers affiliated with CHC.

I understand that "confidential health information" includes diagnoses, diagnostic tests and lab results, and drugs that have been prescribed for me and includes contact information (name, address, social security number, phone number, etc.) and demographic information (gender, race, age, etc.) that is housed in any of the medical records of CHC.

I understand that information released may include mental health, substance abuse, (e.g. drugs, alcohol) and/or HIV/ AIDS status, diagnostic and treatment records. IF I DO NOT WANT THIS INFORMATION DISCLOSED, MY OPTION IS TO NOT SIGN THIS AUTHORIZATION. If I sign this Authorization, such information will be received, used, and disclosed by CHC as authorized by federal law.

I understand that this is a limited Authorization. I am only authorizing the release of confidential health information that included diagnoses, diagnostic tests and lab results, drugs that have been prescribed for me; contact information (name, social security number, address, phone number, etc.} and demographic information (gender, race, age, etc.} that is housed in any of the medical records of CHC or the following health care provider.

Patient Name

Date

Address

Telephone

Patient Signature

Upload document to: Admin: Hippa/Privacy

Consent to Treatment by Volunteers

I understand that services I receive from Community Health Clinic may be provided by a volunteer who is providing care that is not administered for or in expectation of compensation.

I further understand that Texas law imposes limits on the recovery of damages from such a volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

1. The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization.
2. The volunteer commits the act or omission in the course of providing health care services to the patient.
3. The services provided are within the scope of the license of the volunteer, and before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges;
   (a) That the volunteer is providing care that is not administered for or in expectation of compensation; and
   (b) The limitations of the recovery of the damages from the volunteer in exchange for receiving the health care services.

I acknowledge that the health care providers, as volunteers, are providing me with care that is not administered for orin expectation of compensation, and in exchange for receiving the health care services, recovery of damages is limited.

Myself
he following person for whom I am legally responsible

Patient Signature Date

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Community Health Clinic of McKinney COVID-19 Liability Release Waiver

The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions which Community Health Clinic of McKinney (the "Organization") adheres to comply.

In consideration of my participation in the foregoing, the undersigned acknowledge and agree to the following that at any time I enter the clinic:

I have not experienced symptoms that of fever, fatigue, difficulty in breathing, or dry cough or exhibiting any other symptoms relating to COVID-19 or any communicable disease within the last 14 days.

I have not, nor any member(s) of my household, traveled by sea or by air, internationally within the past 30 days.

I did not, nor any member of my household, visit any area within the United States that was reported to be highly affected by COVID-19, in the last 30 days.

I have not been, nor any member{s) of my household, diagnosed to be infected of COVI0-19 virus within the last 30 days.

Following the pronouncements above I hereby declare the following:

I am fully and personally responsible for my own safety and actions while and during my participation and I recognize that I may be in any case be at risk of contracting COVID-19.

With full knowledge of the risks involved, I hereby release, waive, discharge the Organization, its board, officers, independent contractors, volunteers, affiliates, employees, representatives, successors, and assigns from any and all liabilities, claims, demands, actions, and causes of action whatsoever, directly or indirectly arising out of or related to any loss, damage, injury, or death, that may be sustained by me related to COVID-19 while participating in any activity while in, on, or around the premises or while using the facilities that may lead to unintentional exposure or harm due to COVID-19.

I agree to indemnify, defend, and hold harmless the Organization from and against any and all costs, expenses, damages, lawsuits, and/or liabilities or claims arising whether directly or indirectly from or related to any and all claims made by or against any of the released party due to injury, loss, or death from or related to COVI0-19.

By signing below I acknowledge that I have read the foregoing Liability Release Waiver and understand its contents; that I am at least eighteen (18) years old and fully competent to give my consent; That I have been sufficiently informed of the risks involved and give my voluntary consent in signing it as my own free act and deed; that I give my voluntary consent insigning this Liability Release Waiver as my own free act and deed with full intention to be bound by the same, and free from any inducement or representation.

This waiver will remain effective until laws and mandates relevant to COVI0-19 are lifted.

______________________________ ______________

Signature **Date**

____

Print Name

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Telemedicine/Phone Consult Informed Consent

Telemedicine/Phone Consult services involve the use o f telephone and/or secure interactive videoconferencing equipment and devices that enable health care providers to deliver health careservices to patients when located at different sites.

1. I understand that the same standard o f care applies to a telemedicine/phone consult visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will benotified o f and my consent obtained for anyone other than my healthcare provider present in theroom.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. I f it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine/phone consult visit, and that my refusal \vill be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Conunumity Health Clinic at 972-547-0606.
5. I understand that the laws that protect privacy and the confidentiality o f health care information apply to telemedicine/phone consult services.
6. I w1derstand that my health care information may be shared \vith other individuals for scheduling purposes.
7. I nnderstand that this document will become a part o f my medical record.

By signing this fo1m, I attest that I (1) have personally 1ead this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared \vith me in a language I understand; and (3) am located in the state o f Texas and will be in Texas during my telemedicine visit(s).

______________________ Patient/Parent/Guardian Printed Name	______________________ Patient/Parent/Guardian Signature
______________________ Verbal Consent Given (volunteer/staff signature)	______________________ Date

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