Frontera Healthcare Network
Patient Consent

Name_____ Date _____

Consent for the Treatment
The patient named above hereby authorizes and consents to any service, including, but not limited to procedures of diagnostics, radiology procedures, laboratory procedures, surgical treatments, dental, mental/behavioral health, telehealth/virtual services; deemed necessary or advisable by the attending provider(s). Health facilities are not equipped or designed to function as an emergency room.
Initial _____

Physician Assistant / Nurse Practitioner Authorization
I hereby authorize Frontera Healthcare physician to instruct the centers doctor, nurse / or physician assistant to help with certain aspects of my health care. I understand that physicians assistants and/or Nurse Practitioners are not licensed physician and may not treat or diagnose any illness, injury or medical condition except under the supervision and direction of a licensed physician. He/she is a health care professional qualified by academic and clinical education to provide medical services the supervision of a licensed physician, although it is not required the physical presence of the medical supervisor.
Initial _____

Statement of Confidentiality
All the information in this interview and record is confidential and will be protected under the HIPAA privacy rule. We are informing you that information provided during your visit (behavioral health/dental/ and medical) will be part of your electronic health record and will be shared with your immediate healthcare team. This will allow your integrated healthcare team to provide the best comprehensive care. We may use and disclose your protected health information to carry out treatment, payment or health care operations. I have the right to review the notice of client privacy rights prior to signing the consent. I understand that I have the right to request in writing restrictions how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. I understand the center has the right to review and deny this request. I understand that I may revoke this consent in writing, except to the extent that Frontera Healthcare Center has taken action in reliance thereon.
Intitial _____

Insurance Assignment
I hereby authorize payment of Medicare/ Dental/ Other benefits otherwise payable to me, directly to Frontera Healthcare Centers. I also authorize release of any information relating to any claim for myself or minor under my guardianship. I understand that I am responsible for all the costs of treatment to include any services not covered by my insurance benefits. The front office staff will make a copy of your insurance cards to keep on file.
Initial _____

Communication Consent
I hereby authorize Frontera Healthcare Network to contact me via phone, text, and/or email (as applicable) to provide me appointment reminders, balance due reminders, and emergency notifications as needed related to the clinic.
Initial _____

I agree and understand the above Consent for Treatment, Statement of confidentiality, Insurance Assignment, and Communication Consent.

Patient/Guardian Signature _____ Relationship to Patient _____

Witness Signature _____

Frontera Healthcare Network
Patient Registration Form

Email: _____

Patient Information

Name: _____ DOB: _____

Street Address/P O Box _____

City: _____ State: _____ Zip Code: _____

Cell phone: _____ Work phone: _____ Religion: _____

Social Security Number: _____ Marital Status: _____ Sex: M F

Veteran? Y N Student? Y N Employed? Y N Retired? Y N

_____ Hispanic / Latino _____ All other Race: _____

Language in which you are best served: _____

Primary Doctor _____ _____**Phone #** _____

Head of Household Information

Name: _____ DOB: _____

Street address / PO Box: _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Home phone: _____ Work phone: _____

Pharmacy name: _____ Location: _____

Phone number: _____

Person to contact in case of emergency

Name: _____ Relationship: _____

Cell phone: _____ Home phone: _____ Work phone: _____

I hereby authorize the following individual(s) to consent to treatment or services and to verbally give and receive protected health information regarding any treatment or service rendered at FRONTERA HEALTHCARE CENTERS. If any changes occur to this authorization, it will be my responsibility to notify FRONTERA HEALTHCARE CENTERS. Individual(s) listed below must be 18 years of age or older and have a photo I.D.

Name	Relationship	Name	Relationship
1. _____		3. _____	
2. _____		4. _____	

I certify the above information is true and correct. If information is falsified, I am responsible for payment of services.

_____ _____ _____

Patient / Parent / Guardian Date Witness

Frontera Healthcare Network

CERTIFICATION OF INCOME

Name: _____ Date of Birth: _____ Date: _____

I understand that the health center will determine my eligibility based on these figures. I further understand that id I am found to have given inaccurate information, it will be grounds for the health center to disallow my discount and charge me for any discounts received based upon the false information.

Signature _____

MEMBERS OF HOUSEHOLD: (IF APPLYING FOR SLIDING SCALE)

Name	Date of Birth	M/F	Relation
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____

Source of Income	Amount
_____	_____
_____	_____

Yearly Amount _____ # of people in household _____ Code_____

Staff Signature _____ Date _____ Exp. Date_____

Federal Register January 11, 2019

DISCOUNT SCHEDULE BASED ON 2019 HHS FEDERAL POVERTY INCOME LIMITS

Note: No patient will be denied services based upon the documented inability to pay

_____By signing this line, I refuse to provide financial information and that I am aware that I am not eligible for any discounts