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 and Clinic Rights and Responsibilities

Patient Name: _____ DOB: _____ / _____ / _____

Welcome to the center. Our goal is to provide quality healthcare to people 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 healthcare for you. Please read and sign this statement and ask us questions you might have.

Human Rights

You have the right to be treated with respect, regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap / disability, age, veteran status, or other grounds as applicable federal, state and local laws or regulations.

Payment For Services

- 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 are charged a discounted fee.

- You have a right to receive explanations of the centers 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 pre-paid 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.

- Federal law prohibits the center from denying you primary healthcare services which are medically necessary solely because you cannot pay for these services.

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. In certain circumstances, the center may be required to report to the Texas Department of State Health Services regarding your health condition or disease status. A complete discussion of your privacy rights is given to you along with this document and is named the center's Notice of Privacy Practices. Staff request you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices sets forth the ways in which your medical records are used or disclosed by the center and the rights granted to you under the Health Insurance Portability and Accountability Act (HIPAA).

Patient and Clinic Rights and Responsibilities

Healthcare

- You are responsible for providing the center complete and current information about your health or illness, so that we can provide proper healthcare. You have a right, and are encouraged, to participate in decisions about your treatment.

- You have a right to information and explanations in the language you normally speak and in words 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.

- 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 provide it to your legally authorized representative.

- You are responsible for appropriate use of center services, which includes the 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.

- If you are an adult, you have the 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 treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed". You are responsible for the consequences and outcomes of treatment or procedures. If you refuse treatment or procedures that 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).

- You have a right to healthcare and treatment that is responsible 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. The center does not pay for services you receive from another healthcare provider.

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

Center Rules

- 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.

- You are responsible to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments, you may be subject to disciplinary action pursuant to the center's policies and procedures.

Patient and Clinic Rights and Responsibilities

Complaints

- If you are not satisfied with our services, please tell us. We want suggestions so we can improves our services. Staff will you tell you how to file complaints. If you are not satisfied with how the staff handles your complaint, you may complain to the centers Board of Directors.

- If you make a complaint, no center representative will punish, discriminate, or retaliate against you for filing a complaint, and the center will continue to provide you services.

Termination

If the center decides we must stop treating you as a patient, you have a right to advance written notice explaining the reason for the decision, and you will be given thirty (30) days to find other healthcare 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:

- Failure to obey center rules and policies, such as keeping scheduled appointments;

- Intentional failure to accurately report your financial status;

- Intentional failure to report accurate information concerning your health or illness;

- Intentional failure to follow healthcare program, such instructions about taking medications, personal health practices, or follow up appointments, as recommended by your healthcare provider(s), and / or

- Creating a threat to the safety of the staff and / or other patients.

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 Board. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

Signature: _____ Date: _____

Printed name: _____

If signing for a minor, print minor's name: _____

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

Patient Medical History

Patient name: _____ Date: _____

Patient History			**Family History**		
Asthma	Y	N	Asthma	Y	N
Cancer	Y	N	Cancer	Y	N
COPD / chronic bronchitis	Y	N	COPD / chronic bronchitis	Y	N
Diabetes	Y	N	Diabetes	Y	N
Digestive problems	Y	N	Digestive problems	Y	N
Ear / hearing problems	Y	N	Ear / Hearing Problems	Y	N
Epilepsy / seizures	Y	N	Epilepsy / Seizures	Y	N
Eye / vision problems	Y	N	Eye / vision problems	Y	N
Heart disease	Y	N	Heart disease	Y	N
High blood pressure	Y	N	High blood pressure	Y	N
Kidney disease	Y	N	Kidney disease	Y	N
Memory problems	Y	N	Memory problems	Y	N
Musculoskeletal problems	Y	N	Musculoskeletal problems	Y	N
Stroke	Y	N	Stroke	Y	N
Surgeries	Y	N	Surgeries	Y	N
Thyroid problems	Y	N	Thyroid problems	Y	N
Weight changes	Y	N	Bleeding disorder	Y	N
Hospitalization	Y	N	Osteoporosis	Y	N

Please explain any / all issues marked "yes" (Y) above (use back if you need more room)

_____

_____

Medications: _____

_____

_____

Allergies: _____

_____

Social History			**Date of last**			
Smoker	Y	N	Blood work	_____	Eye exam	_____
Drink alcoholic beverages	Y	N	Colonoscopy	_____	Dental exam	_____
Ever used illegal drugs	Y	N	Flu shot	_____	Hep B vac	_____
Live alone	Y	N	Mammogram	_____	Pap smear	_____
Major life stressors	Y	N	Pneumonia vac	_____	Prostate exam	_____
			Tetanus vac	_____	TB test	_____

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