Welcome to
Caring Hands Healthcare Centers

We are a Federally Qualified Community Healthcare Center providing primary and preventative care for families and individuals of all ages regardless of ability to pay. We offer a *SLIDING FEE DISCOUNT* to uninsured patients based on income and number of people in the household. One of our trained Intake Specialist will gladly answer any questions you may have.

ABOUT US

Caring Hands Healthcare Centers are local, non-profit, community healthcare facilities. We strive to improve access to primary and preventive care and to effectively manage chronic illness. We provide high quality, cost effective care and help divert costly Emergency Room visits and ER overcrowding.

VISION

Caring Hands Healthcare Centers excel in providing compassionate, family health care with a *SPIRIT OF EXCELLENCE* that is culturally appropriate and accessible.

WHAT TO BRING TO APPOINTMENTS

- Driver's license or State Identification Card
- International Work Visa
- Passport
- Proof of Income
- Proof of Residence
- Insurance Card
- Medicaid Card
- Medicare Card

Thank you so much for choosing Caring Hands Healthcare Centers for you and your family's healthcare needs.

How did you hear about Caring Hands? _____

CARING HANDS HEALTHCARE CENTERS

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

Thank you for choosing our office.
In order to serve you properly we will need the following information. All information will be strictly confidential
PLEASE PRINT

PATIENT INFORMATION

Patient's last name:	First:	M I:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Nickname:

Social Security no.:	Birth Date:	Sex:
		❑ Male ❑ Female

Street Address	City:	State:	ZIP Code:
Billing Address	City:	State:	ZIP Code:
Home Phone	Day Phone	Cell Phone	Work Phone
Email	Driver's License Number	Occupation	Employer's Name
Marital Status (circle one) Single / Mar / Div / Sep / Wid	Student ❑ **Full – Time** ❑ **Part – Time** ❑ **Not a current student**	Veteran ❑ **Yes** ❑ **No**	Smoker ❑ **Yes** ❑ **No**

Number of people in household	Estimated Annual Household Income (Net)
	❑$0-$25,000 ❑$25,000-$45,000 ❑$45,000-$60,000 ❑$60,000 & Above

Race	Hispanic	Homeless	Migrant Worker	Primary Language	Public Housing
	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**		

Is this patient covered by insurance?	❑ Yes	❑ No	
Please indicate primary insurance	❑ Medicaid	❑ Medicare	❑ Self-Pay ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Home phone no.:	Work phone no.:

I, the undersigned, certify that I (or my dependent) have insurance with _____ and assign directly to Caring Hands Healthcare Centers, Inc. all insurance benefits, if any, otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Caring Hands Healthcare Centers, Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to be responsible for payment of all services rendered on my behalf (or my dependent). I understand that payment is due at the time of service, unless other arrangements have been made. In the event that payments are not received by agreed upon dates, I understand that refusal to be seen can and will be enforced until payment is rendered.

Patient/Guardian Signature _____ Date _____

PATIENT'S CONSENT TO TREATMENT/FOLLOW-UP

CARING HANDS HEALTHCARE CENTERS

Date: _____

1. I,_____,(the) _____
   (Name of person giving consent) (Relationship, if other than patient)
   Hereby consent to voluntarily to outpatient care, passing diagnostic procedures, examination and medical treatment including (but not limited to) routine work (such as blood, urine and other studies), heart tracing and administrations of medication prescribed by the physician and/or psychiatrist. Also, consent is given for examinations by physician's assistants or physician's designees, as necessary in the medical or day treatment staff's judgement. Also, consent is given for mental health services to be provided by the means of group rehabilitation and/or individual therapy, and to follow-up treatment after discharge, if applicable.

2. I further consent to the performance of minor surgery, mole removal, suturing lacerations, Etc.

3. I further consent to the photographs or X-Rays necessary for diagnosis and for education purposes.

4. I further consent to immunizations and/ or screening exams (including PPD test, Influenza, Pneumococcal, TB, etc.) for my child or myself. I also, give consent for this information, regarding immunizations, to be released to other Health Care Providers, Schools, Daycares, and / or Department of Human Services.

5. I understand that only appropriately trained personnel will do these procedures.

6. **RELEASE OF INFORMATION:** I authorize the clinic to release medical and /or mental health information to third party insurance carriers for the purpose of filing insurance claims related to my medical or mental health care. I authorize the Licensed Social Workers access to all medical or mental health records. I authorize the clinic to release medical and/ or mental health information to medical hospitals and or mental health hospitals in case of an emergency situation.

7. I understand that this consent form will be valid and remain in effect as long as I use the clinic, or until released in writing.

8. This form has been fully explained to me and I understand its contents.

COMMENTS:_____

_____

I have read and understand the Patients Right and Responsibilities, and understand them. The receptionist and/or the social worker has fully explained to me any questions that I may have had. I agree to abide by the Patient's Rights and Responsibilities.

_____ _____

Signature of patient or person authorized to consent for patient **Signature of person(s) who explained the form**

If the Patient is a minor or is unable to consent, complete the following

1.) Patient is a minor ___ year(s) of age.

_____ _____

(Name of Father) (Name of Mother)

2.) Patient is unable to consent because

_____

_____

CARING HANDS HEALTHCARE CENTERS

Sliding Fee Scale

Caring Hands Healthcare Centers, Inc. strives to make healthcare affordable. CHHC accepts Medicare, Medicaid and most types of health insurance. We also offer a **Sliding Fee Scale** discount for those patients who do not have insurance **or** who have insurance with a high deductible. To qualify for this discount, you must meet certain income guidelines and provide **Proof of Income**. The chart below illustrates the Sliding Fee Scale formula used to determine the availability of reduced charges to patients who qualify according to the number in the household and the average yearly household income.

Initial Office Visit Established Office Visit # In Family	A $25 (0-100%)	B $45 $35 (101%-125%)	C $55 $45 (124%-150%)	D $75 $60 (151%-175%)	E $90 $80 (176%-200%)	F Full Fee (>200%)
1	$0 $12,060	$12,061 $15,075	$15,076 $18,090	$18,091 $21,105	$21,106 $24,120	>$24,121
2	$0 $16,240	$16,241 $20,300	$20,301 $24,360	$24,361 $28,420	$28,421 $32,480	>$32,481
3	$0 $20,420	$20,421 $25,525	$25,526 $30,630	$30,631 $35,735	$35,736 $40,840	>$40,841
4	$0 $24,600	$24,601 $30,750	$30,751 $36,900	$36,901 $43,050	$43,051 $49,200	>$49,201
5	$0 $28,780	$28,781 $35,975	$35,976 $43,170	$43,171 $50,365	$50,366 $57,560	>$57,561
6	$0 $32,960	$32,961 $41,200	$41,201 $49,440	$49,441 $57,680	$57,681 $65,920	>$65,921
7	$0 $37,140	$37,141 $46,425	$46,426 $55,710	$55,711 $64,995	$64,996 $74,280	>$74,281
8	$0 $41,320	$41,321 $51,650	$51,651 $61,980	$61,981 $72,310	$72,311 $82,640	>$82,641

For each additional family member over 8 add $4,180.

CARING HANDS HEALTHCARE CENTERS

Sliding Fee Scale

HOW TO READ THE SCALE

Step 1: Locate the row corresponding to the number of individuals in your family.
Step 2: Move to the right until you find the range containing your average annual income.
Step 3: Go to the top of that column. The Letter will correspond to the **Office Visit Fee** you will pay.

Column	**A**	**B**	**C**	**D**	**E**	**F**
Initial Office Visit		**$45**	**$55**	**$75**	**$90**	
Flat Fee Office Visit	**$25**	**$35**	**$45**	**$60**	**$80**	**Full Fee**

(Procedures, Lab, and Radiology will be charged in addition to Office Visit Fee.)

*** You Must Provide <u>Proof of Income</u> by presenting at least one of the items listed below:**

- Tax Forms from the most recent year
- Paycheck stubs for three months with year to date income provided
- Fixed income statement (example: pension, social security or bank statements showing deposits)
- Signed notarized letter from, example: Minister, Law enforcement, City hall or Lawyer verifying financial status, housing situation, and how you cover expenses.
- Student grant information
- If you are self-employed, tax forms from current year and a profit/loss statement.

REMEMBER - All household income is to be included.

CARING HANDS HEALTHCARE CENTERS

REMEMBER – All household income is to be included

HOUSEHOLD INCOME

We offer our patients a discount on their medical bills if they qualify for our sliding fee scale. The discounted percentage is based on the NET income of ALL members of the household and the number of members in the family. If you wish to apply for this discount we need income verification. INCOME MUST BE VERIFIED. YOU WILL BE ASKED TO APPLY TO PROGRAMS THAT MAY OFFER ADDITIONAL ASSISTANCE.

Income

Number in Household

LIST ALL FAMILY MEMBERS	Date of birth
1	
2	
3	
4	
5	
6	
7	

For office use only

Sliding Fee%_____

Document Received _____ **Verified By_____**

Sooner Care Paper work filled out_____

Income Verification Scanned into Patient Record _____

I affirm *that all of the foregoing information and statements submitted in this application and its attachments and supporting documents are true and correct to the best of my knowledge, and that all responses to the questions are full and complete, omitting no material information.*

Patient/Guardian signature _____ Date _____

Office Staff _____ Date _____

Privacy Policy

Caring Hands Healthcare Centers, Inc. is not able to discuss any of your private information with anyone without your specific permission, unless it is required or permitted by law (immunizations, workman's compensation claims, and subpoenas). This form is for those patients that give their permission for someone else in their household or family member to discuss any information with us. You have to give us their full name and relation to you.

I authorize Caring Hands Healthcare Centers, Inc. to discuss medical information with the following person(s)

_____

_____

_____

_____ _____

Signature of Patient/Guardian **Date**

Health Information Exchange

We may participate in a health information exchange (HIE). Generally an HIE is an organization in which providers exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical error will occur. By participating in a HIE, we may share your health information with other providers that participate in the HIE or participants of other health information exchanges. If you do not want your medical information to be available through the HIE, you must request a restriction. You can do so by completing an Opt-Out form from the Registration Clerk

_____ _____

Signature of Patient/Guardian **Date**

Voicemail

I authorize Caring Hands Healthcare Centers, Inc. to leave messages on my voicemail/answering machine concerning appointment verifications and/or reminders.

_____ _____

Signature of Patient/Guardian **Date**

I have received a copy of Caring Hands Healthcare Centers, Inc. Patient Rights and Responsibilities.
I have received a copy of Caring Hands Healthcare Centers, Inc. Health Information Rights.
I have received a copy of Caring Hands Healthcare Center, Inc. After Hours Care Policy.
I have received a copy of Caring Hands Healthcare Centers, Inc. No Show Policy.
I have received a copy of Caring Hands Healthcare Centers, Inc. Sliding Fee Scale.
I have received a copy of Caring Hands Healthcare Centers, Inc. Medication Refill Policy.

Printed Patient/Guardian Name (print) _____

Patient/Guardian Signature_____ **Date**_____

Caring Hands Representative_____

Advance Directive Consent Form

I acknowledge that Caring Hands Healthcare Centers, Inc. has provided me with written information concerning Advance Directives. I have checked the following:

____ I have provided the Center with a copy of my duly executed Advance Directive.

____ I will complete the "Advance Directive Interim Form" until I can provide the Center with a copy of my duly executed Advance Directive.

____ I would like more information about Advance Directives.

____ I do not desire any additional information about Advance Directives.

Patient/Guardian (print) _____ **Date** _____

Patient/Guardian Signature_____ **Date of Birth** _____

CARING HANDS HEALTHCARE CENTERS

Medical Home Agreement

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ***ongoing, quality*** and ***safe*** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your ***PCP,*** to meet ***all*** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report ***any*** changes related to your health, treatments, medications, etc.
   This includes use of ***all medications*** - prescription, over-the-counter, herbal and street drugs.
   This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us ***before*** going to the Emergency Room, unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.

_____ _____

Patient or Guardian Signature Date

_____ _____

Provider Signature Date

After Hours Care

CHHC provides after hours care at our McAlester location Monday through Thursday until 6pm. For a medical emergency such as shortness of breath, chest pain, or profuse bleeding please seek immediate medical attention at the nearest emergency facility or call 911. For other medical problems/questions that you have after our normal business hours, please call 918-426-2442 and press 1 for our Nurse on Call Service.

Medication Refill Policy

Please call you pharmacy for medication refills. The pharmacist will contact your provider if necessary. BE SURE TO CALL AT LEAST TWO DAYS BEFORE YOUR MEDICATION RUNS OUT. If you run out of your medication before you call, they may not have the medication you need. Please call your pharmacy before picking up your medication to ensure that your prescription is ready.

No Show Policy

If the patients no shows excessively, 3 times for adults, 5 times for children under the age 18, the patient will only be able to schedule appointments on a SAME DAY basis. For each appointment that the patient "no call, no shows" for, the patient or parent will receive a letter informing them of the policy and the outcome of their actions. If the patient should persist in not keeping their SAME DAY appointments without calling 3 times for adults, 5 times for children under the age 18, the patient ***WILL*** be discharged from Caring Hands Healthcare Centers, Inc.

"NO SHOW" means: Failure to show up **30 minutes early** for **new patients** and to be **15 minutes early** at scheduled appointment time for **all other patients**.

CARING HANDS HEALTHCARE CENTERS, INC.
PATIENT RIGHTS AND RESPONSIBILITIES

It is the goal of Caring Hands Healthcare Centers, Inc.'s (CHHC) board of directors and staff to provide quality, cost effective health services with dignity and respect to all people, without regard to their ability to pay, culture, or lifestyle and to provide the information and support to promote their participation in health care decisions. We respect your rights as a patient and recognize that you are an individual with unique health care needs. We want you to know your rights as a patient as well as your obligations to yourself, other patients, and your health care provider, and the organization. We encourage a partnership between you and your healthcare team. You're most important role as a member of this team is to exercise you rights and take responsibility by asking for clarification of things you do not understand. These rights extend to your family and/or significant other.

YOU HAVE THE RIGHT TO:

- **Considerate and respectful care.** We respect your right to expect quality treatment within the scope of our mission, select your healthcare provider whenever possible and be treated with dignity, regardless of race, religious beliefs, culture values, gender, age, or financial status. We respect your right to be treated in the least restrictive environment consistent with your condition, ask all personnel involved in your care to introduce themselves, state their role in your care, and to explain what they are doing for you. We respect your right to participate in care decisions, receive prompt evaluation and management of pain, and access your medical records. We respect your right to a safe and secure environment, and to access emergency services as provided through after hours call.
- **Information about treatment.** Your health care team will describe the proposed treatment(s) to you. You can expect them to explain your condition and proposed treatment(s), your role in your care and the knowledge and skills you need, any alternative treatments, the expected outcome and problems related to your health needs, and the benefits and risks of each alternative. It is your right to be informed of education or training activities involved in your treatment. You will be asked if you wish to participate in these activities, and you have the right to refuse to participate.
- **Participate in decisions about your care.** We respect your right to informed consent in partnership with your care provider to agree to treatment based on a full explanation of your health challenges and the risks/benefits of the proposed treatments and alternatives. We respect your right to refuse a diagnostic procedure or treatment. It is your right to decide whether you wish to be treated, and if you do, by which method of treatment. If you elect treatment you will be informed of the medical consequences of this decision and asked to sign consent to refuse treatment. If you are a minor, your family and/or legal guardian may be involved in treatment planning decisions with you.
- **Pain Management.** We respect your right to have your pain assessed and managed. We encourage you to discuss your pain and pain management with your provider so you can make proper decisions.
- **Ethical Decisions.** We understand that from time to time you and your family may be faced with making difficult treatment choices. We respect your right to make individual decisions that are based on your personal beliefs and values as well as on the available medical information. You or your legally designated representative has the right to be personally involved in the consideration of all ethical issues involving your care. We recognize your right to question all information as presented to you by your health care team. If you do not clearly understand any information given to you, you have the right to continue questioning until the information and/or options and decisions are clear to you.
- **Privacy.** CHHC respects the privacy of all patients. Case discussion, examination, and treatment are confidential and will be conducted discreetly. You have the right to a safe and secure environment.

- **Confidentiality.** You have the right to expect that all of your medical records are confidential unless you give written permission to release information or reporting is required or permitted by law (immunizations, workmen's compensation claims, and subpoenas).
- **Reasonable Response to Request & Needs.** You have the right to considerate and respectful care within the scope of CHHC's mission. Should you need services not provided by CHHC, you have the right to be assisted in transferring to another health care facility that can provide the needed services. The need to transfer you to another facility will be explained to you and/or your significant other. You have the right to examine your bill, ask questions and receive and explanation of charges.
- **Complaints/Suggestions.** You have the right to voice complaints and suggestions regarding the quality of care and services you receive, and you are assured that the presentation of a complaint or suggestion will in no way compromise your access to care. If you have a complaint or feel your rights are not being respected, please let the staff know, or call the clinic supervisor. You have the right to place your complaint(s) or suggestion in writing. A Patient Suggestion Form may be obtained from any staff member and at the front desk. We encourage you to place your complaints and suggestions in writing so that we can follow up and take corrective action as appropriate.

PATIENT RESPONISBILITY:

- **Provide complete medical information.** Provide to the best of your knowledge, accurate and complete information about your present health status and your complete medical history, including illnesses, hospitalizations, medications, advance directives and other matters related to your health.
- **Make informed decisions.** Because you are responsible for the decisions you make about your care, we encourage you to gather as much information as you need to make decisions. Once you and your health care team have decided on a plan for treatment, be sure to advise them if you feel unable to follow the flan. You may be asked to consent in writing for certain special procedures. Ask as many questions as you must to fully understand each document you are asked to sign.
- **Understand.** Understand your role in your care and the knowledge and skills you need.
- **Know about your health problems.** If there is anything you do not understand, ask any member of your health care team to explain it to you.
- **Report Changes.** Tell your care team about any changes in your health.
- **Accept financial obligations.** Ensure that your financial obligations are fulfilled as promptly as possible.
- **Respect the privacy of others.** It is important to be considerate of other patients by observing their right to privacy, and helping to maintain a clean and quiet atmosphere.
- **Conduct and treatment of others.** You have the responsibility to treat other patients and CHHC staff with respect and dignity.
- **Lifestyle.** Your health depends not just in the care you receive at CHHC, but, in the long term on the decisions you make in your daily life. You are responsible for recognizing the effect of lifestyle on your personal health

HEALTH INFORMATION RIGHTS

Right to Inspect and Copy: You have the right to see and have a copy of the health information that CHHC has about you. It will not include information needed for civil, criminal, administrative actions and proceedings, or psychotherapy.

Right to Request and Amendment: If you fell the health information we have about you is wrong or incomplete, you may ask us in writing to fix the information. We may say no to your request if it is not in writing and it does not include a reason, or the information was not created by us, or the information is determined to be correct and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" a list of the names we gave your health information to, other than disclosures for purposes of treatment, payment or operations. Your request must not go back more than six years and must not include dates prior to April 14, 2003

Right to request Restrictions: You have the right to ask to ask to either not give or partially giver your health care information used for treatment, payment or heath care operations. We do not have to agree to your request. If we do agree, we will follow your request for restriction unless the information is used to provide you emergency care.

Right to Request Confidential Communication: You have the right to ask that we talk with you about health care matters in a certain way or at a certain place. For example, you ask that we only contact you at work or by e-mail. CHHC will work to meet all reasonable requests.

Right to a Paper Copy of this Notice: You have the right to ask for a paper copy of this notice

CHHC provides after hours care at our McAlester location Monday through Thursday until 6pm.
For a medical emergency such as shortness of breath, chest pain, or profuse bleeding please seek immediate medical attention at the nearest emergency facility or call 911.
For other medical problems/questions that you have after our normal business hours, please call 918-426-2442 and press 1 for our Nurse on Call Service.