CARING HANDS
HEALTHCARE CENTERS
QUALITY AFFORDABLE CARE

How did you hear about Caring Hands?

____

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.	Preferred Name/Nickname:	Social Security Number:	Birth Date:
Birth Sex: ☐Male ☐Female	Gender Identity (18+) ☐Male ☐Female ☐Declined ☐Other ☐Transgender Male (FtoM) ☐Transgender Female (MtoF)	Sexual Orientation (18+) ☐Straight ☐Gay ☐Lesbian ☐Bisexual ☐Other ☐Declined	
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	Employers Name
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow/Widower		Student: ☐Full-Time ☐Part-Time ☐Not a current student	
Homeless: ☐Yes ☐No	Migrant Worker: ☐Yes ☐No	Primary language	Public Housing
Race:	Hispanic: ☐Yes ☐No	Veteran: ☐Yes ☐No	Smoker: ☐Yes ☐No
# of people in household:	Please indicate primary insurance: ☐Medicaid ☐Medicare ☐Self-Pay ☐Commercial Insurance		

If you have Medicaid/Medicare or Commercial Insurance, what is your annual household income? $______________
☐Refuse to Report

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	Home Phone #

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 ______________

Consent for Treatment and for Use of Health Information

1. I ___________________ (patient name) give permission for **Caring Hands Healthcare Center** to provide me diagnostic and therapeutic treatment utilizing any of the services the center may provide as deemed necessary or advisable during my care.

2. I allow **Caring Hands Healthcare Center** to file for insurance benefits to pay for the care I receive. I also allow Caring Hands Healthcare Center to use my health information for its operational needs, such as peer review and quality assurance.

   I understand that:
   - **Caring Hands Healthcare Center** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand that:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.
   - That my health information may be shared according to the Notice of Privacy Practices as provided to me and acknowledged in writing by me

___________________________________ ________________

Patient's Signature Date

___________________________________ ________________

Parent or Guardian Signature Date
(for children under 18)

December 2019

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Notice to Patient or Patient's Legally Appointed Representative:

We are required to provide you with a copy of our Notice of Privacy Practices which describes how Caring Hands Healthcare Centers, Inc may use or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may decline to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of the Notice of Privacy Practice for Caring Hands HealthCare Centers.

______________________________ ______________________
Signature **Date**

____
Printed Name

Relationship to the Patient if not signed by the Patient personally (*i.e.,* legal guardian, holder of durable power of attorney for health care, health care proxy, parent of a minor patient)___

FOR OFFICE USE ONLY

Caring Hands Healthcare Centers, made every effort to obtain the written acknowledgement of receipt of this practice's Notice of Privacy Practices from this patient but was unable to do so because:

- ☐ **The patient or legally appointed representative of the patient refused to sign**
- ☐ **It was impossible to obtain a signature because of an emergency situation**
- ☐ **Other (provide specific details):**______________________________

______________________________ ______________________
Employee Signature **Date**

____
Employee Printed Name

December 2019

Designation of Individuals Whom My Providers Can Discuss My Healthcare

Federal rules that our practice must follow protect the privacy and security of your health information. All the ways we use your health information and your rights under the Health Insurance Portability and Accountability Act, or HIPAA, are described in our Notice of Privacy Practices that you were offered when you first received care from us.

In the course of our providing care to you, you may wish to make it easier for us to speak with your family members and others who may assist in my care. If you bring someone with you to your appointment and you bring them into the examination room with you, we consider that to be your consent to allow us to discuss your care in front of them. If you do not want them to be included in our discussion, please ask them not to come with you into the exam room. Sometimes your family members and others help you with your healthcare needs. If there is someone in particular you wish for us to be able to talk with about your healthcare needs, please complete this form and sign it prior to leaving our office. Please return this form to the reception upon completion. This will allow us to communicate with someone you trust about your care and treatment. The amount and type of information that will be shared about you with the person you designate is shared in the careful discretion of your healthcare provider. Examples of how we share your information include talking with you about your care in front of anyone you bring with you into the exam room, talking with your adult child designated on this form to help with your medical bills, and responding to questions about your medications with the person you designate.

If you wish for anyone to receive a copy of your medical records, a different form called an Authorization to Disclose Protected Health Information must also be signed by you.

This office has permission to disclose information regarding my medical care to the following specific person(s):

____ ____

____ ____

____ ____

This designation to share information to the individual(s) named above will remain in force until such time as I revoke it in writing.

I understand and have been provided with a Patient Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this office reserves the right to change the notice and practices, but that prior to implementation, a copy of any revised notice will be provided.

I understand that I must revoke this consent in writing, except to the extent the organization has already taken action.

____

Patient's Full Name

____ ____

Signature of Patient or Legal Representative if minor Printed Name and Relationship to Patient

____

Today's Date (Effective date of notice)

Contact Authorization

I hereby authorize Caring Hands Healthcare Centers to contact me regarding my care or the care of someone I am legally responsible for using text to my phone, email, or voice mail.

My phone number for text and/or voicemail is ________________

My email address is _________________________________

__________________________________ (Signature) ________________________ (Date)

This authorization if effective until rescinded by the signatory or by Caring Hands Healthcare Centers

December 2020

Name:
Address:
City, State:
Zip Code:
Telephone:
Date of Birth:

Caring Hands Healthcare Centers, Inc.
P.O. BOX **1992**
McAlester, OK 74502

Sliding Fee Eligibility Form

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in our center in strict confidence You must verify your income at least **once a year**. Your yearly income tax return with a copy of your W-2 form, payroll check stubs covering the past **two pay periods**, or copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

Today's Date: ______ Number of people living in your home? ______

Do you own or rent your home? ☐ Own ☐ Rent ☐ Live with Someone

Amount of Household Income?

You	Your Spouse	Your Children	Other Person	Total Family Income

Place of Employment?

You	Your Spouse	Your Children	Other Person

Do you receive any income from any source, including the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Rental Income					
Retirement Pension					
Royalty/Interest Income					
Other (Specify)					
Other (Specify)					
Other (Specify)					
Other (Specify)					

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes, list below ☐ No ☐

Give Names, DOB, and SSN of all individuals living in the household.

Name:	Date of Birth:	Social Security Number:

I declare the above information is true and have given **Caring Hands Healthcare Centers, Inc.** permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that providing false information may disqualify me from receiving a discount and may jeopardize my status at **CHHC** and/or be punishable by law. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Signature:	Date:	*Clinic Purpose Only* Income Code:

CHHC Staff Verification Signature ______________________ Date ____________

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 __________