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:

Street Address	City:	State:	Zip Code:

Billing Address	City:	State:	Zip Code:

Birth Sex: ☐ Male ☐ Female	Cell Phone:	Home Phone:	Day Phone:

Email:	Pharmacy:	Primary language:	Hispanic: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower	Race:	Public Housing: ☐ Yes ☐ No

Homeless: ☐ Yes ☐ No	Migrant Worker: ☐ Yes ☐ No	Veteran: ☐ Yes ☐ No	Smoker: ☐ Yes ☐ No

# of people in household: _____	What is your annual household income? $_____

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.

Initials_____

This authorization is effective until rescinded by the signatory or by Caring Hands Healthcare Centers

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	Cell 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.
   - The acceptance of family planning service will not be a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in, any other program that is offered by the grantee.
   - 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 (for children under 18) **Date**

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

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)

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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 _____

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:

- Work with us, as your PCP, to meet all of your health care needs.
- Communicate with us about all your healthcare concerns and goals.
- Report any changes related to your health, treatments, medications, etc.
  - This includes use of all medications - prescription, over-the-counter, herbal and illicit drugs.
  - This also includes any medical equipment being used or that has been ordered or recommended for use.
- Call us before going to the Emergency Room, unless it is life threatening.
- Notify us after any Emergency Room, Urgent Care Clinic or Hospital visit.
- Schedule medical appointments in a timely manner, including follow-up appointments.
- Keep appointments as scheduled with us and any appointments scheduled with a specialist.
- If you cannot keep an appointment call before your appointment time to cancel or reschedule the appointment.

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**

Last Revised 01/04/2024

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Clinic Expectation

We, at Caring Hands Healthcare Centers, are committed to providing the highest level of care and service to all our patients. This document outlines the expectations for both the clinic and the patient to ensure a smooth and efficient experience for everyone.

Our Commitment:

- We are dedicated to providing you with personalized and professional care.
- We will strive to schedule appointments that are convenient for you and minimize waiting times.
- We will clearly communicate treatment options and associated costs.

Your Commitment:

To ensure efficient use of our resources and timeliness for all patients, we kindly request you to:

- Call 24 hours in advance to cancel or reschedule your appointment.
- Arrive on time for your scheduled appointment.
- Understand that being 15 minutes late will be considered a no-show.

No Show Appointments:

"No Show" Does not arrive for their scheduled appointment, cancels with less than required notice, or arrives more than the allowed grace period late.

- After 3 no shows for adults and 5 for children under the age of 18, will be considered as walk-in only.
- Availability for walk-ins will be confirmed upon arrival.

Patient Signature: _____ Date_____

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

CARING HANDS
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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 household income at least once a year. Paycheck stubs, fixed income statements, a CHHC Circumstance Form, self employment income records and/or your most recent bank statement. Your annual household income will be used to calculate the level of your payment

Todays Date: _____ Number of people in Household: _____

Do you have any type of insurance that will cover all or a portion of your medical expense? If yes, please list below.

Please list Names and Dates of Birth for all individuals living in the household below.

Name	Date of Birth

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 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.

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY

Please indicate source for proof of income and amount listed on the documents:

Sources	Patient	Other household member	Other household member	Totals
Most Recent Paycheck Stubs				
Fixed Income Statement (SSDI, retirement)				
CHHC Circumstance Form				
CHHC Employer Verification Form				
Self Employment Income (profit loss form, 1040 form)				
Most Recent Bank Statements (One month)				
CHHC Staff Verification Signature: _____			Date: _____	