WELCOME TO OUR CLINIC... Your health is our #1 priority!

Community Healthcare Center, including Pediatric Associates, Family Health Center on Virginia, and Women’s Health Center of McKinney, is proud to announce adoption of the “Medical Home” model of health care. This new, innovative, team-based approach to providing health care focuses on the partnership between you the patient, and the Center’s health care team. We will work together to coordinate the services you need and provide the best care possible.

<table>
<thead>
<tr>
<th>Medical – Wichita Falls</th>
<th>Monday through Friday</th>
<th>7:45 a.m. to 4:45 p.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Healthcare Center</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Juarez Medical Clinic</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Pediatric Associates</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Walk-In Hours</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 11:00 a.m.; 2:00 p.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Zundy</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Vernon College</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td><strong>TodayCare at Community Healthcare Center</strong></td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Adults</td>
<td>Saturday</td>
<td>8:30 a.m. to 12:00 p.m.</td>
</tr>
<tr>
<td>Children</td>
<td>Monday, Tuesday &amp; Friday</td>
<td>7:45 a.m. to 4:30 p.m.</td>
</tr>
<tr>
<td><strong>Medical – Vernon, Texas</strong></td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Children</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td><strong>Medical - McKinney</strong></td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Family Health Center on Virginia</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Women’s Health Center of McKinney</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td><strong>Dental – Wichita Falls</strong></td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Phyllis Hiraki Dental Clinic</td>
<td>1st &amp; 3rd Saturday of the month</td>
<td>8:30 a.m. to 12:00 p.m.</td>
</tr>
<tr>
<td><strong>Dental - McKinney</strong></td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td>Family Health Center on Virginia</td>
<td>Monday through Friday</td>
<td>7:45 a.m. to 4:45 p.m.</td>
</tr>
<tr>
<td><strong>Pharmacy – Wichita Falls</strong></td>
<td>Monday through Friday</td>
<td>8:00 a.m. to 12:00 p.m.; 1:00 p.m. to 4:45 p.m.</td>
</tr>
</tbody>
</table>

**MINORS**
Patients under 18 years of age must be accompanied by a parent or legal guardian in order to receive routine treatment. Legal guardians must bring proof of guardianship.

**SERVICES and STAFF**
We offer the following services: primary medical care, primary dental care, pediatric care, prenatal care, counseling, lab, x-rays (in Wichita Falls), screening tests, immunizations, pharmacy, and eligibility assistance.

**PAYMENT FOR SERVICES RECEIVED**
Fees charged are on a sliding fee scale based on your household income and family size. Payment should be made at the time of service. Community Healthcare Center welcomes Medicare, Medicaid, CHIP, most STAR plans, TRICARE, insurance, cash, checks, and credit cards.

(Continued on back)
AFTER HOURS
if you have a medical illness that cannot wait until your clinic site opens, you may call the following and speak to the “after hours” on-call service.

Wichita Falls, Texas:
- Community Healthcare Center 940.766.6306
- Pediatric Associates 940.696.1600

McKinney, Texas:
- Family Health Center on Virginia 214.618.5600
- Women’s Health Center of McKinney 469-325-3003

You will be given advice on how to handle your illness. This service is not to be used for medication refills, appointment scheduling or billing issues. If you have a dental emergency, we do have walk-in availability during normal business hours.

PRESCRIPTIONS
Unplanned refills require a minimum of 48 hours for completion. A follow-up visit will be scheduled every three months for maintenance medications, unless otherwise noted by your primary care provider. There are several ways our patients can be assisted with prescription costs. Please ask your provider or the pharmacy about these services. Controlled substances are not stocked onsite at our Pharmacy in Wichita Falls.

FUTURE VISITS – IT IS IMPORTANT TO KEEP YOUR APPOINTMENTS
Remember to bring your medications to every visit. Should your work situation, insurance coverage, or address change, it is your responsibility to make us aware of those changes. When you know you cannot keep your appointment, please make every attempt to cancel the day before. This will allow us to help another patient.
GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better information about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: Community Healthcare Center, (Hereinafter called the “Center”) encourages individuals to seek a personal primary care provider for periodic health examinations and for treatment of health problems. The Center services are targeted primarily toward prevention of health problems among those who cannot access a primary care provider. The Center cannot assume the responsibility for payment of medical care received or performed outside the Center, including the delivery of babies, reference lab and/or other diagnostics, etc., even if such care was ordered by Center providers, unless previous authorization has been given by Center’s Administration.

DISCLAIMER: Among its services, the Center utilizes screening tests, including certain blood tests, which are a method of identifying individuals who are at risk for developing several common medical problems. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the Center, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, diagnostic imagining, injections, medications, perform clinical photography as needed for treatment purposes, and render other health services to the patient identified on this form. Parental consent is not required for prenatal care of patients who are still minors.

INFORMED UNDERSTANDING: I understand that no warranty or guarantee has been made to me as to the result of cure from care and treatment provided.

RELEASE OF INFORMATION: I further understand that all Medical and Social Service Records may be released to representatives of the United States Department of Health and Human Services and to representatives of programs or projects funded by this Department and other funding sources for the purposes of determining contract compliance with Federal/State law and regulations. Community Healthcare Center utilizes the MED-IT system for Breast and Cervical Cancer Services (BCCS), and IMMTRAC for immunizations.

CONTRACT PHARMACIES: I understand that Community Healthcare Center provides services through contract pharmacies and/or other vendors and my personal health information may be shared with these pharmacies and/or other vendors so that I can receive improved access to affordable medications and/or healthcare.

TEACHING FACILITY: I understand and acknowledge that Community Healthcare Center is a teaching center, and my care, and/or the care of patient(s) I am a guardian for, may be provided by a clinician, including but not limited to medical students and/or resident physicians and/or resident dentists, in a clinical training program. I further understand and acknowledge that teaching services such as direct observation by other physician and medical students, case discussions, or photographic or video images of care activities involving myself or my dependents are allowed for teaching.

Revised 3/2022
QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in, and that any questions I have had about the service have been answered to my satisfaction. I further certify that I have read or had read to me* the Client and Center Rights and Responsibilities and accept that document.

SIGNATURES: Fill blank lines with NA if not applicable.

SECTION I:
Patient’s Name ______________________________ Signature ____________________________
Person Authorized to Consent (if not patient) __________________ Relationship ______________
Signature ___________________________________________ Date _______________________

SECTION II:
Counselor Name: ____________________________ Signature: __________________________
Date ______________________________

*Translated into __________________________ / Read to me by __________________________
Signature of Person translating or reading consent to patient:
________________________________________
Date: ______________________________

Client #: ____________________________
Welcome to the center. Our goal is to provide quality health care 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 health care for you. Please ask us questions you might have.

Human Rights: You have a right to be treated with respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age Vietnam era veteran status, or other grounds in accordance with applicable federal, state and local laws or regulations.

Payment for Services:
1. You are responsible for giving staff accurate information about your present financial status and any changes in your financial status. The staff needs 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 will be charged a discounted fee.
2. You have a right to receive explanations of the center’s 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 prepaid 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.
3. Federal law prohibits the center from denying you primary health care 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. The Notice of Privacy Practices will explain how your medical records may be used or disclosed by the center and the rights granted to you under the Health Insurance Portability and Accountability Act (“HIPAA”).

Health Care:
1. You are responsible for providing the center complete and current information about your health or illness, so that we can give you proper health care. You have a right, and are encouraged, to participate in decisions about your treatment.
2. You have a right to information and explanations in the language you normally speak and in words that 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.
3. 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 will provide it to your legally authorized representative.
4. You are responsible for appropriate use of center services, which includes
   • following staff instructions,
   • making and keeping scheduled appointments,
   • and requesting a “same day” 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.
5. If you are an adult, you have a 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 such treatment or procedures. Your receipt of this information is necessary so that your refusal will be “informed.” You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you
refuse treatment or procedures that your 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).

6. You have a right to health care and treatment that is reasonable 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 that you receive from another healthcare provider.

7. **We are not a pain management clinic.** If you are in pain, you have a right to receive an appropriate clinical assessment of your pain, in a manner that is consistent with your age, condition, and ability to understand. You have a right to be informed of treatment options for pain management, allowing you to make an informed decision regarding your treatment plan.

**Center Rules:**

1. 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.
2. You are responsible for the supervision of children you bring with you to the center. You are responsible for your children’s safety and the protection of other patients and our property.
3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments, you may be jeopardizing your status as a patient at the Center.

**Complaints:**

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Staff will tell you how to file a complaint. If you are not satisfied with how the staff handles your complaint, you may complain to the center’s Board of Directors.
2. 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 that we must stop treating you as a patient, you have a right to advance written notice of the decision, and you will be given thirty (30) days to find other health care 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:

1. Failure to obey center rules and policies, such as keeping scheduled appointments;
2. Intentional failure to accurately report your financial status;
3. Intentional failure to report accurate information concerning your health or illness;
4. Intentional failure to follow the health care program, such instructions about taking medications, personal health practices, or follow up appointments, as recommended by your healthcare provider(s);

You have a responsibility to treat center staff and providers with respect and dignity. This Center maintains ZERO TOLERANCE of abuse, harassment, violence, or any other criminal behavior. A person who commits, causes or threatens to cause abuse, harassment, violence, or criminal behavior of any kind is subject to immediate termination as a patient of the Center and/or removal from the Center premises. Plus, you have the potential of being barred from all sites.

**Appeals:** If the center has given you notice of termination of the patient and center relationship, you have the right to appeal. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask for corrections to your medical record.
- You can ask, in writing, for corrections to be made to your medical record, if you think it is incorrect or incomplete.
- If we say "no" to your request, a written response will be provided to you within 60 days, explaining the reasons why the request for correction was denied.

Ask for confidential communications.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to reasonable requests.

Ask for limits on how your information is used or shared.
- You can ask us not to use or share certain confidential information for treatment, payment or operations. We are not required to agree with your request, and can say "no" if it would affect your care.
- If you pay in full, out-of-pocket, for a service or healthcare item, you can ask us not to share that information with your insurance company for the purpose of payment or operations. You may be asked to sign a form at the time you make this request. We will say "yes" to your request unless we are required by law to share that information.

Get a list of those with whom we have shared your health information.
- You can ask for a list of the times we have shared your information for up to six years prior to the date of the request, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment or operations, and certain disclosures that you have requested.
- You can receive one list for free but any additional requests within a 12 month period will be provided to you at a reasonable cost.

Notice of Privacy Practices.
- You can ask for a copy of this privacy notice at any time, even if you have agreed to receive the notice electronically. We will promptly give you a paper copy.

Choose someone to act for you.
- If you have given someone medical power of attorney, or you have a legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure that the person has the authority and can act for you before we take any action.

For certain information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations listed below, talk to us and let us know what you want us to do, and we will follow your instructions.

In these cases you have the right and it is your choice to tell us:
- To share information with family, friends, or others involved in your care.
- To share information in a disaster relief situation.
- To include your information in any directories that we create.
- To contact you regarding any fundraising efforts.

If you are not able to tell us your preference, for example, if you are unconscious, we may share your information if we believe it is in your best interest, or if needed lessen a serious or immediate threat to health or safety.

In these cases, we will never share your information without your written permission:
- Marketing purposes (i.e. - Advertising, Brochures, Radio, TV, Signs)
- Social Media (i.e. - Facebook, Twitter, LinkedIn)
- Sale of your information
- Most sharing of mental health (psychotherapy) notes.

In the case of fundraising efforts:
- You have the right to tell us not to contact you anymore.
How do we typically use or share your health information? We typically use or share your health information (electronic, written, or oral) in the following ways:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>To treat you</td>
<td>• We can use your health information and share it with other professionals such as specialists who are treating you.</td>
</tr>
<tr>
<td>For payments</td>
<td>• We can use or share your health information to bill and get payment from insurance companies for the health care services you received.</td>
</tr>
<tr>
<td>To run our organization</td>
<td>• We can use or share your health information to run our practice, improve your care, and contact you as necessary.</td>
</tr>
</tbody>
</table>

How else can we use or share your health information? We are allowed or required to share your information in other ways—usually in ways that contribute to the public good such as public health and research. We have to meet many conditions of the law before we can share your information for these purposes. For more information, see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| Help with public health or safety issues. | • We can share information about you for certain situations such as:  
  • Preventing diseases  
  • Helping with product recalls  
  • Reporting adverse reactions to medications  
  • Reporting suspected cases of abuse, neglect or domestic violence  
  • Preventing or reducing a serious threat to anyone’s health or safety |
| Health research                        | • We can use or share your information for health research.                                                                                         |
| Required by law                        | • We will share your information when required to do so by federal or state laws. When requested, your information will be shared with the Department of Health and Human Services if it wants to see if we are complying with the law. |
| Tissue and organ bank requests          | • We can share health information about you with organ banks.                                                                                      |
| Requests from medical examiner or funeral director | • We can share health information with the medical examiner, coroner, justice of the peace, or funeral director, when you die.                     |
| Worker's compensation, law enforcement, or other government requests | • We can share health information about you:  
  • For worker’s compensation claims  
  • For law enforcement investigations  
  • Health oversight agencies for activities authorized by law.  
  • For special government functions such as military, national security, and presidential protective services. |
| Response to lawsuits legal actions     | • We can share health information about you in response to a court or administrative order, or in response to a subpoena.                         |

We are required by law to maintain the privacy and confidentiality of your health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

How can you file a complaint if you think your rights have been violated? If you think your health information has been accessed, used or shared inappropriately, you can file a complaint. We will not retaliate against you for filing a complaint.

You can file a complaint with the Compliance Office at Community Healthcare Center by sending a letter to:

Community Healthcare Center  
Attn: Compliance Officer  
200 Martin Luther King Jr. Blvd.  
Wichita Falls, TX 76301

Or by calling (940) 766-6306, or online at [www.chcwf.com](http://www.chcwf.com)

You can file a complaint by sending a letter to:

U.S. Department of Health and Human Services Office for Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Or by calling 1-877-696-6775, or online at [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
Patient’s Name: ____________________  ____________________
Date of Birth: __________________
□ Male  □ Female

Social Security #: __________________
Marital Status: □ Single  □ Married  □ Divorced  □ Widowed

Parent/Guardian Name: ____________________  ____________________
Date of Birth: __________________

Home Address: ____________________  ____________________  Apt #: ____________________________
City: ____________________  State: ____________________  Zip: ____________________

Home #: ____________________  Alternate #: ____________________  Email Address: ____________________

Employer: ____________________  Work #: ____________________

Emergency Contact: _______________________________________________________________________
Relationship to patient: ____________________  Phone #: ____________________

Insurance Company: ____________________  Policy Holder: ____________________
Policy Holder’s DOB: ____________________  ID #: ____________________  Group #: ____________________

To meet requirements for our funding sources, we need the following information on each patient. Thank you for your assistance!

<table>
<thead>
<tr>
<th>What is your race? (Check the box that applies)</th>
<th>What is your ethnicity? (Check the box that applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Asian  □ African American  □ American Indian</td>
<td>□ Latino  □ Non-Latino</td>
</tr>
<tr>
<td>□ Native Hawaiian  □ Pacific Islander  □ White</td>
<td>□ Not reported (Staff initial)</td>
</tr>
<tr>
<td>□ More than one race  □ Unreported (Staff initial)</td>
<td></td>
</tr>
</tbody>
</table>

Are you a US Veteran?  □ Yes  □ No
Are you a farm worker?  □ Yes  □ No
If yes: □ Migrant or □ Seasonal

Do you live in public housing?  □ Yes  □ No
Are you homeless?  □ Yes  □ No
If yes, please check the correct description:
□ Shelter  □ Transitional  □ Doubling Up  □ Street

What is your sexual orientation/gender identity? Please check the box that applies.
Patients 0-17 years are not required to complete these fields.

<table>
<thead>
<tr>
<th>Sexual Orientation:</th>
<th>Gender Identity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Straight  □ Gay  □ Lesbian</td>
<td>□ Male  □ Female  □ Transgender Male (FTM)</td>
</tr>
<tr>
<td>□ Bi-Sexual  □ Other  □ Unknown</td>
<td>□ Transgender Female (MTF)  □ Unknown</td>
</tr>
<tr>
<td>□ Decline to Answer (Staff initial)</td>
<td>□ Neither exclusively male or female  □ Other</td>
</tr>
<tr>
<td></td>
<td>□ Decline to Answer (Staff initial)</td>
</tr>
</tbody>
</table>

Notice of Privacy Practices:
□ I have received the Health Center’s Notice of Privacy Practices.

Rights and Responsibilities:
□ I have received Health Center’s Notice of Rights and Responsibilities.

________________________________________________  ____________________________
Patient Signature  Date

________________________________________________  ____________________________
Parent/Legal Guardian  Date

Revised 3/2022
Assignment of Benefits

I request payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf payable to North Central Texas Community Health Care Center, Inc. (NCTCHCC). I authorize any holder of medical information about me to release to Medicare, Medicaid or other identified payers and their agents any information needed to determine these benefits or benefits for related services.

I understand I am required to provide a copy of my or my dependent’s insurance card and inform NCTCHCC of any change in insurance coverage.

I understand that I am responsible for all charges and NCTCHCC will bill my insurance carrier on my behalf. If my insurance carrier requests other information from me, such as evidence of coordination of benefits (if it is identified by the insurance company that I or my dependent may be covered under more than one insurance policy), I will promptly contact the insurance company to ensure prompt payment to NCTCHCC and avoid unnecessary charges to my account.

If I am seeking care for a dependent, I acknowledge that I am responsible for enrolling any newborn dependents with in 28-30 days of birth for them to be covered on my policy. I understand I am responsible for all charges until coverage for my newborn is active.

Name of Beneficiary (Person Receiving the Service): _______________________________________

☐ Medicare-Medicare ID: ___________________  ☐ Traditional  ☐ Medicare Advantage
☐ Medicaid-Medicaid ID: ___________________  ☐ TX MCD  ☐ Amerigroup  ☐ Superior
☐ FirstCare  ☐ Molina  ☐ Cigna Healthspring
☐ Aetna  ☐ Parkland  ☐ Other ____________
☐ CHIP Coverage-CHIP ID: ___________________  ☐ Molina  ☐ Amerigroup  ☐ Superior
☐ Parkland  ☐ Other________________
☐ Private Insurance (BCBSTX, UHC, Aetna, etc.)  Subscriber ID: _________________________
Group ID: ______________________________
Company: ______________________________

I certify that the information given by me is true and correct.

Signature _____________________________________________ Date__________________________
(Beneficiary or Legal Guardian)

Notice Concerning Complaints: Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants, acupuncturists and surgical assistants may be reported for investigation at the following address: Texas Medical Board; Attention: Investigations; 333 Guadalupe, Tower3, Suite 610; P.O. Box 2018, MC-263; Austin, TX 78768-2018. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information you may visit the website at: www.tmb.state.tx.us.

940-766-6306
940-766-6504 (fax)
200 Martin Luther King, Jr. Blvd, Wichita Falls, Texas 76301-1152
Please circle the range of annual household income for your family size.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Range of Annual Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$13,590 or less</td>
</tr>
<tr>
<td></td>
<td>$13,591 - $20,520</td>
</tr>
<tr>
<td></td>
<td>$20,521 - $27,180</td>
</tr>
<tr>
<td></td>
<td>More than $27,180</td>
</tr>
<tr>
<td>2</td>
<td>$18,310 or less</td>
</tr>
<tr>
<td></td>
<td>$18,311 - $27,646</td>
</tr>
<tr>
<td></td>
<td>$27,647 - $36,620</td>
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<tr>
<td></td>
<td>More than $36,620</td>
</tr>
<tr>
<td>3</td>
<td>$23,030 or less</td>
</tr>
<tr>
<td></td>
<td>$23,031 - $34,773</td>
</tr>
<tr>
<td></td>
<td>$34,774 - $46,060</td>
</tr>
<tr>
<td></td>
<td>More than $46,060</td>
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<tr>
<td>4</td>
<td>$27,750 or less</td>
</tr>
<tr>
<td></td>
<td>$27,751 - $41,900</td>
</tr>
<tr>
<td></td>
<td>$41,901 - $55,500</td>
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<tr>
<td></td>
<td>More than $55,500</td>
</tr>
<tr>
<td>5</td>
<td>$32,470 or less</td>
</tr>
<tr>
<td></td>
<td>$32,471 - $49,026</td>
</tr>
<tr>
<td></td>
<td>$49,027 - $64,940</td>
</tr>
<tr>
<td></td>
<td>More than $64,940</td>
</tr>
<tr>
<td>6</td>
<td>$37,190 or less</td>
</tr>
<tr>
<td></td>
<td>$37,191 - $56,153</td>
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<tr>
<td></td>
<td>$56,154 - $74,380</td>
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<tr>
<td></td>
<td>More than $74,380</td>
</tr>
<tr>
<td>7</td>
<td>$41,910 or less</td>
</tr>
<tr>
<td></td>
<td>$41,911 - $63,280</td>
</tr>
<tr>
<td></td>
<td>$63,281 - $83,820</td>
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<tr>
<td></td>
<td>More than $83,820</td>
</tr>
<tr>
<td>8</td>
<td>$46,630 or less</td>
</tr>
<tr>
<td></td>
<td>$46,631 - $70,407</td>
</tr>
<tr>
<td></td>
<td>$70,408 - $93,260</td>
</tr>
<tr>
<td></td>
<td>More than $93,260</td>
</tr>
<tr>
<td>9</td>
<td>$51,350 or less</td>
</tr>
<tr>
<td></td>
<td>$51,351 - $77,533</td>
</tr>
<tr>
<td></td>
<td>$77,534 - $102,700</td>
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<tr>
<td></td>
<td>More than $102,700</td>
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<tr>
<td>10</td>
<td>$56,070 or less</td>
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<tr>
<td></td>
<td>$56,071 - $84,660</td>
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<td></td>
<td>$84,661 - $112,140</td>
</tr>
<tr>
<td></td>
<td>More than $112,140</td>
</tr>
</tbody>
</table>

___________________________________________  __________________________
Patient/Guardian Signature                  Date

Chart # ____________________________

Revised 2/1/2022
Sliding Fee Application

_____________________________________________  _______________________________________
Last Name                                                                                       First Name

_____________________________________________  _______________________________________
Date of Birth                                                                                     Phone Number

Are you employed? □ Yes □ No  

_____________________________________________
Name of Employer

Do you receive: □ Social Security □ Unemployment?

Please list spouse and dependents living in your household:

Name ___________________________ DOB _______________ Relationship __________________

Name ___________________________ DOB _______________ Relationship __________________

Name ___________________________ DOB _______________ Relationship __________________

Name ___________________________ DOB _______________ Relationship __________________

Name ___________________________ DOB _______________ Relationship __________________

Name ___________________________ DOB _______________ Relationship __________________

By my signature below I attest that the information provided herein is complete and accurate. I understand that I may be required to provide additional information and documentation upon request for the purpose of determining my eligibility to participate in the Sliding Fee Discount Program. I agree to inform CHC of any changes of condition or circumstance that might impact my eligibility to participate in the Discount Program. I understand I am responsible for a minimum of at least $35 at the time of each medical visit unless other arrangements have been made.

_____________________________________________  _______________________________________
Patient/Guardian Signature                                                                       Date

Office Use only

Household Income: $_______________ Family Size: _______ Percent of Poverty: ______%
Type of Income: □ Check Stub □ W2 □ Award Letter □ Other: ____________________________
PM System Updated: □ YES □ NO Expiration Date: ____________________________

_____________________________________________  _______________________________________
Staff Signature                                                                                  Date

Revised 3/2022
CONSENT TO TREAT A CHILD

Child’s Name: ____________________________ Date of Birth: _________________ Chart #: __________

I, _____________________________________, _______________________________ as parent/legal guardian of the
PRINTED NAME RELATIONSHIP TO CHILD
above named child, give my permission to the following persons listed below to bring the above named child to
Community Healthcare Center (and any of its service locations) for treatment and to consent to all
immunizations, injections, or other medical therapies and procedures as they seem appropriate.

<table>
<thead>
<tr>
<th>PRINTED NAME</th>
<th>DATE OF BIRTH</th>
<th>RELATIONSHIP TO THE CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

If there is any change in the above list, I will inform the clinic in writing immediately.

________________________________________  ______________________  ______________________
Signature                                      Date                                       Telephone Number

________________________________________  ______________________  ______________________
Witness Signature                               Date                                       Witness Printed Name

Effective March 2022
HIPAA RELEASE OF INFORMATION

Patient Name: ____________________ Date of Birth: ________________

Please list anyone you give us permission to speak with regarding your protected health information. This information may include: diagnosis, test results, recent visits, medication requests, appointment information, and billing/insurance information.

I authorize the release of my personal health information to the following:

Name ____________________ Relationship _____________ DOB _____________
Name ____________________ Relationship _____________ DOB _____________

This authorization will remain in effect until revoked by me in writing.

________________________________________  __________________________
Signature                                      Date

________________________________________  __________________________
Witness                                       Date

This does not authorize copies of protected health information to be released, mailed, or faxed to the person(s) listed. To obtain paper copies of protected health information, a valid HIPAA release is required.
ADVANCE DIRECTIVE HANDOUT

What is an advance directive?

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.

What is a living will?

A living will is one type of advance directive. It is a written, legal document that describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will doesn't let you select someone to make decisions for you.

What is a durable power of attorney for health care?

A durable power of attorney (DPA) for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

What is a do not resuscitate order?

A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.

Should I have an advance directive?

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

People who are seriously or terminally ill are more likely to have an advance directive. For example, someone with terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase
her peace of mind and increase her control over her death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.

**How can I write an advance directive?**

You can write an advance directive in several ways:

- Use a form provided by your doctor.
- Write your wishes down by yourself.
- Call your health department or state department on aging to get a form.
- Call a lawyer.
- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

**Can I change my advance directive?**

You may change or cancel your advance directive at any time, as long as you are able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.
Patient Centered Medical Home

What does it do for me?

*Patient-centered* is a way of saying that you, the patient, are the most important person in the health care system. You are at the center of your health care.

*A medical home* is an approach to providing total health care. With your medical home, you will join a team that includes health care professionals, trusted friends or family members (if you wish), and—most importantly—you.

The **mission** of the Patient Centered Medical Home (PCMH) model is to enable our patients to lead healthier lives through a strong, long-lasting relationship with their primary care provider and care team. This relationship-based approach involves patients and their families partnering with care teams to benefit from services that keep people healthy, from head to toe.

Our **vision** is to become the leading provider of choice for north Texas families by involving patients and their families in health care decisions. Care teams will maintain consistent contact with patients and communicate with them in ways they feel most comfortable and can best understand.

### Goals

1. Provide care and services that meet as many of our patients’ health care needs as possible.
2. Engage patients and families in their health care decisions and behaviors, and help them establish and meet goals that improve their quality of life.
3. Communicate with patients in ways they prefer and that best meet their unique needs.
4. Ask patients how they feel about the care they receive, and change how we provide care based on their feedback.
5. Provide patients with superior, 24-hour access to care by phone or our web-based patient portal accessible through our website.

### Patient Rights

You the patient have the right to:

- **Choose your own personal primary care clinician.** When you call to make an appointment as a first time patient, you will be given an opportunity to select your primary care provider. If you have already established care with one of our providers and you wish to change to someone else, you have the right to ask for a different provider.

- **Make informed decisions** about your treatment options and establish goals to improve your health. You will also be asked to set goals at each visit, and progress will be monitored each time you come in for a follow up.

- **Coordinated care between your primary care provider and specialist** involving consistent communication and exchange of information.

- **Coordinated care between your primary care provider and the hospital** concerning information about why you were admitted, your medications, and any tests or procedures you had done.

- **Obtain a second opinion** from one of Community Healthcare Center’s providers or from an outside clinician.

- **Your opinion** about the services you receive and to share that opinion with us. We want to provide you with the best care possible, and welcome your suggestions to help us do it.

- **Health care you can access when you need it.** This means that if you need clinical advice when our office is closed, you can still access the information you need anytime—day or night—simply by calling our main office number at (940) 766-6306. If you are calling because of a medical emergency, please call 911.