Healing Hands Ministries

Hope for the spirit. Health for the body!

8515 Greenville Avenue, Suite N-210
Dallas, TX 75234
(214) 221-0855

ENROLLMENT REQUIREMENTS FOR SLIDING FEE PATIENTS

1. Proof of Household Income from everyone in the household who works

- Most recent **pay check stubs**, *OR*
- **Tax return**, *OR*
- **Employer statement of income** which states gross income and frequency of pay. This letter must be **dated, signed** and include a **telephone number**.

Proof of benefits received from

- **Food Stamps**
- **Public Housing**
- **TANF**
- **SSI**
- **Child Support**

2. Valid Picture ID and **Insurance Card** if any

All information provided must be current, dated within the last 30 days.
Please make sure to bring all required documents at time of registration.

Registration Hours:
Monday – Friday
8:30 – 11:00 AM
1:00 – 4:00 PM

You will need to recertify every year before the expiration date of December 31. To recertify you will be required to bring in the updated documents mentioned above.

- Recertifications are accepted October 1 - December 31 for the following year**.**
- Please recertify at the clinic, Ste N-108.

Transportation for medical appointments at Healing Hands Ministries is provided for patients that live in the Dallas County.

- Please call us at (214) 221-0855 ext. 123 or 124 to make arrangements.
- Please call at least one week before your appointment.
- Transportation is only available for appointments scheduled prior to 2:00 PM.

HHM Administrated 1.1.07, Revised 8.30.16

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Registration Form/Forma de Registración

Date/*Fecha:* _____/_____/_____ Referred by/*Referido por*: _____

Name/Nombre: _____
Last/*Apellido* **First/*Primer Nombre*** **MI/*Segundo Nombre***

Male/Masculino:___Female/Femenina:___ SS#:_____Married/Casado:___Single/Soltero:___

Date of birth/*fecha de nacimiento:*_____Ethnicity/Ethia: Hispanic, Not Hispanic
Month/*Mes* **Day/Día** **Year/año** **Circle one/Circule Uno**

Race/Raza: Asian, Black or African American, White, Other:_____ Language/Idioma:_____
Circle one/Circule Uno

Current Address/*Dirección Actual*: _____ Apt # _____

City/*Ciudad*: _____State/*Estado*: _____Zip Code/*Código*: _____

Permanent Address/Direccion Permanante:_____

Home Phone/*Teléfono hogar*(_____)_____

Cell(_____)_____Work Phone/Teléfono de su trabajo (_____)_____

Email Address/Correo Electrónico:_____ Preferred Contact Method: Hm, Wk, Cell, Email
Circle one/Circule Uno

In case of an emergency, contact/ En caso de una emergencia, contacte a:
Name/*Nombre*___ _____Phone/T*eléfono*: _____
Relationship to patient/Relación con el paciente:_____

Do you have medical insurance, Medicaid or Medicare? If Yes, What do you have?_____ NO_____
¿Tiene Aseguranza Medica, Medicaid O Medicare? Si tienes una, Cual es?_____ No _____

Insured Name and DOB_____Relationship to insured_____
Nombre De La Aseguranza y Fecha De Nacimiento Relacion con el Asegurado

****

Complete this section if you are enrolling for the Healing Hands Ministries Sliding Fee Program
Complete esta secion si esta registrando para el programa de descuento de Healing Hands Ministries

# of people living in your household/*# de las personas que viven en su casa*: _____
List Name(s)/Nombre(s): _____

Do you receive federal or state assistance? Yes _____ No _____ Which? _____
¿Recibe asistencia federal o estatal? Si _____ No _____ *Cual* ?_____

What is your gross (before taxes) monthly **household** income? $_____
¿Cuál es el ingreso normal (antes de impuestos) ***del hogar*** *por mes*? $ _____

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Healing Hands Ministries Partnership in Care Agreement

Healing Hands Ministries is pleased to be a partner with you in your healthcare. We know that managing your health includes you being involved. You, as a patient, are in control of your health. The choices that you make every day have an impact on your health. Your diet, exercise and other decisions you make impact your health as much as or more than any physician.

We are committed to educating you about your health and working with you. Having better information and taking an active role can help you make healthier decisions. We encourage you to ask questions and share ideas with our healthcare team.

We will encourage you to take an active role in your healthcare by making the following wise choices for each visit that you have:

1. Always bring all medications that you are taking with you to each visit. (prescription drugs, over-the-counter medicines, vitamins, and herbal remedies and supplements)
2. Make a list in advance of things that you may want to discuss at your appointment.
3. Be sure to make transportation plans in advance and arrive 20 minutes early to each appointment.
4. Be sure to ask questions if you don't understand something.
5. Follow the plan of treatment recommended by your physician.
6. Take all medications as directed.
7 Respond to all communications from the clinic.
8 Please review the clinic rules, be compliant, and keep a copy of them with your records.
9 Inform of any address, telephone number(s), income or insurance changes.
10 24 hours in advance notice if unable to keep appointment.
11 Arriving late for an appointment will result in being rescheduled for the next available time.
12 I understand my treatment may be unsuccessful if I fail to follow the physician's orders and referrals.
13 There is no cell phone usage or any charging of cell phones in the clinic.
14 HHM reserves the right to refuse services to patients that have conducted themselves in a manner that is considered inappropriate. (uncooperative, verbally abusive, intoxicated , etc.)

Patient: _____ _____
Signature Date

Screener: _____ _____
Signature Date

Printed name of patient_____
Last First

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HIPAA Authorization Release Form

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, _____, an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

□ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse_____
Child(ren)_____
Parent(s)_____
Other_____

□ Information is not to be released to anyone.

Complete the following by indicating those items that you want you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

□ **All health information**	□ History/Physical Exam	□ Past/Present Medications	□ Lab Results
□ Physician's orders	□ Patient Allergies	□ Operation Reports	□ Consultation Reports
□ Progress Notes	□ Discharge Summary	□ Diagnostic Test Reports	□ EKG/Cardiology Reports
□ Pathology Reports	□ Billing Information	□ Radiology Reports & Images	□ Other_____
□ Mental Health Records (excluding psychotherapy notes)		□ Genetic Information (including Genetic Test Results)	
□ Drug, Alcohol, or Substance Abuse Records		□ HIV/AIDS Test Results/Treatment	

Signature_____**Date**_____

Signature of Individual or Individual's Legally Authorized Representative

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TERMINATION

This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

RE-DISCLOSURE

By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person or persons whose name(s) is/are written above, and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require my authorized persons to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

INSTRUCTIONS TO MY AUTHORIZED PERSONS

My authorized persons shall have the right to bring a legal action in any applicable form against any covered entity that refuses to recognize and accept this authorization for the purposes I have expressed. Additionally, my authorized persons are authorized to sign any documents that the authorized persons deem appropriate to obtain the protected medical information.

VALID DOCUMENT

A copy or facsimile of this original authorization shall be accepted as though it were an original document. WAIVER AND RELEASE I hereby release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my authorized persons.

Signed on the _____ day of _____, 20_____.

_____

Signature of Individual or Individual's Legally Authorized Representative

_____

Print Name

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Consent for Treatment and Payment

Name of Patient: _____ **Date of Birth:** ____/____/____

Name of person giving consent if different from Patient:

[Print Name]: _____

Relationship to Patient: □ Self □ Parent □ Guardian □ Other: _____

I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services to me at the center's service locations. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent, or until the center changes its services and asks me to complete a new consent form..

I understand that payment for medical service is due on the day of the visit. Payment may be made by cash or credit card. Insurance/Financial arrangements should be made with the center prior to any service.

Consent Provisions

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that midlevel providers (Physician Assistants, Family Nurse Practitioners and Trained Medical Assistants) may be involved in my treatment and I consent thereto.
4. I understand that I may be asked to sign a separate informed consent form for certain Treatment(s).
5. I hereby voluntarily give my consent to Treatment to the Center.
6. I the undersigned authorize the center to release any information acquired in the course of my treatment to my insurance company (s), another physician or medical facility (s). I hereby agree that I am responsible for said fee (s). I authorize payment directly to and assign to the center, if any,

_____

Signature of Patient/Legal Representative **Date**

_____

Print Name **Relationship to Patient**

_____

Signature of Witness, if not patient **Print Name** **Date**

Interpreter/Translator to complete when applicable:

I have accurately and completely read/translated the foregoing document to:

_____

Insert the Patient's or Patient's Legal Representative's Name

In _____, the Patient's or Patient's Legal Representative's primary language. S/He understood all of the terms and conditions and acknowledged his/her agreement and consent thereto by signing the document in my presence.
Interpreted/Translated

By: _____
Signature of Interpreter/Translator

_____

Print Name of Interpreter/Translator: **Date**

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Consent to Treatment by Volunteers

Your signature on this form shows that you understand that the doctors or nurses who will be treating you may be working here as an unpaid volunteer. Because they may be working for free, they are protected by law from lawsuits for any harm you may experience as their patient, if they are acting in good faith. The page below will explain further limits on their liability as medical volunteers.

Consent to Treatment by Volunteers

I understand that services I receive from HHM may be provided by a volunteer who is providing care that is not administered for or in expectation of compensation.

I further understand that Texas Law imposes limits on the recovery of damages from such a volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

1) The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization.

2) The volunteer commits the act or omission in the course of providing health care services to the patient.

3) The services provided are within the scope of the license of the volunteer, and before the volunteer provides health care services, the patient or, the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges;

a) That the volunteer is providing care that is not administered for or in expectation of compensation; and

b) The limitations of the recovery of damages from the volunteer in exchange for receiving the health care services.

I acknowledge that the health care providers, as volunteers, are providing me with care that is not administered for expectation of compensation, and in exchange for receiving the health care services, recovery of damages is limited.

( ) Myself
( ) The following person for whom I am legally responsible: _____

Patient's signature:_____ Date:_____

Screener's signature:_____ Date:_____

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