MEHOP
Matagorda Episcopal Health Outreach Program

Matagorda Episcopal Health Outreach Program (MEHOP) is a Federally Qualified Health Center (FQHC).
To provide the best clinical care for our patients we are required to collect detailed information about you in which a health record will be established and maintained for each patient who receives services at our health center. All information is strictly confidential. Your personal information will not be released without your consent and knowledge.

Patient Registration Form

Last Name	First Name	Preferred Name : (If Applicable)

Social Security Number	Date of Birth	Mailing Address	City	State

Zip Code	County	Sexual Orientation:	Gender	Sex at Birth
		○ Lesbian, Gay, Homosexual ○ Straight or Heterosexual ○ Bisexual ○ Something else ○ Don't know ○ Choose not to disclose	○ Male ○ Female ○ Transgender Male [F-to-M] ○ Transgender Female [M-to-F] ○ Other ○ Choose not to disclose	○ M ○ F
Main Phone Number	Other Phone Number			
Email Address:	Family Size			

Preferred Method of Contact (if needed circle more than one) :

Cell Phone Text (SMS) Email US Mail Patient Portal

House Hold Income	Ethnicity:	Race:	Housing Status:
☐ Monthly ☐ Annually Amount $_____	☐ Hispanic ☐ Non-Hispanic	☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Black/ African American ☐ White ☐ American Indian ☐ More than one Race ☐ Refuse To report	○ Not Homeless ○ Doubling Up ○ Homeless Shelter ○ Other ○ Street ○ Unknown ○ Transitional

Patients Choices- Please Read Carefully and select "Yes" or "No" to the following Questionnaire

We need your permission to allow MEHOP to electronically exchange your health information with other health care providers, entities, and yourself. The Exchange is secure and improves the speed, quality, safety and cost of the patient's care and experience. Do we have your permission? ***Yes*** *or* ***No***

We would like your permission to send you SMS text messages and/or Email for Appointment Confirmation. Do you allow SMS messaging? (please circle one) **Yes** or **No** If Yes, please provide Cell Phone Number

_____

Do you consent to using the Exchange to ensue speed and reliability? *(Please Circle One)* **Yes** or **No**

Do you consent to using the Immunization Registry? *(Please Circle One)* **Yes** or **No**

Do you consent to using our Patient Portal? *(Please Circle One)* **Yes** or **No**

Please Continue on the Next Page

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Last Name	Language Best Served In:	Attending School?	Grade Completed?
		o YES o No	K 1 2 3 4 5 6 7 8 9 10 11 12

Veteran Status	Are you currently Active Military?	MEHOP offers eligibility services - Would you be willing to participate?	Do you have Medicare? #?	Medicaid? #?

Do you have Medical/ Dental insurance?	If YES, is it through your employer?	Agricultural Status:	Marital Status:
		o Dependent of Migrant o Dependent of Seasonal o Migrant Worker o Not Agricultural Worker o Seasonal Worker	o Single o Married o Divorced o Widowed o Separated o Life Partner o Unknown
Subscribers Name	Subscribers Date of Birth		
Subscribers Social Security #	Policy Number:		

Secondary Insurance Company Name:	Policy Number:

Secondary Insurance Information:	Person Financially responsible for this account?	Emergency Contact Information: Is it ok to leave a message with your emergency contact? o Yes o No	Spouse Information:
Subscribers Name: DOB: SS#:	Name: Mailing Address: Telephone: Relationship to Patient	Name: Mailing Address: Telephone: Relationship to Patient:	Name of Spouse: Birthday: Telephone:

If Patient is a Minor

How did you hear about MEHOP?	Parent or Guardian name/Relationship	Parent or Guardian Social Security #	Parent or Guardian Date of Birth	Sex	Marital Status

Please Continue on the Next Page

MEHOP
Matagorda Episcopal Health Outreach Program

	Patient Initial
Assignment of Benefits: I hereby authorize and Direct my insurance carrier(s) plans to issue payment directly to Matagorda Episcopal Health Outreach Program (MEHOP) for medical, pediatrics, OB/GYN, dental, and behavioral health services rendered to myself and/ or my dependents. Regardless of my insurance benefits, I understand that I am responsible for any amount not covered by my insurance benefits.	
Authorization to Release Information: I hereby authorize Matagorda Episcopal Health Outreach Program (MEHOP) to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment. This order will remain in effect until revoked by me in writing.	

I solemnly swear (or affirm) that the information included on this form is true and to the best of my knowledge.

Signature of Patient or Guardian	**Date**
Printed Name	**If Not Patient List Relationship**
Witness Signature	**Date**

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

Matagorda Episcopal Health Outreach Program

101 Ave F North, Bay City, Texas 77414
Phone (979) 245-2008/Toll Free 1-877-705-2008 Fax: (979) 245-0744

CONSENT TO TREATMENT

I (for) undersigned patient, do hereby voluntarily consent to such health care involving routine diagnostic procedures and medical/dental/behavioral health treatment by my attending physician/dentist/behavioral health provider, his/her assistants or his/her designees. I am aware that the practice of medicine/dentistry/behavioral health and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this episode of care. I understand that the attending physician/dentist/behavioral health may not be an agent of the Matagorda Episcopal Health Outreach Program (MEHOP), and may have been granted privileges by MEHOP to practice medicine/dentistry/behavioral health and to use the facilities of MEHOP. I further understand that the nurses/hygienist and other technical staff at MEHOP do not practice medicine/dentistry/behavioral health, but carry out the orders of independent licensed physicians/dentists/behavioral health providers when providing treatment to patients at MEHOP.

MEDICAL CARE

Independent contractors furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, emergency room physicians, and others may bill directly for their services. MEHOP provides only general duty nursing care unless the physician orders that the patient be provided more intensive nursing care. If the patient's condition requires the service of a special duty nurse or sitter, this service must be arranged by the patient or patient's representative since MEHOP does not provide this special care. When protective side rails are placed on the patient's bed and raised for patient protection or when protective restraints are ordered, the patient assumes all risks of injury or damage if the patient refuses to permit raised side rails or restraints.

CONSENT FOR STUDENTS

_____ I understand that: MEHOP is a teaching clinic and that medical students, who may because doctors, nurses, or other health students, may assist in my treatment at any MEHOP clinic.

CONSENT TO PHOTOGRAPH

_____ For security and identification purposes, MEHOP is authorized to take photos of patients to place in the patient's chart. (Requirement for new security system.)

_____ MEHOP is authorized by the patient to use photos for publicity purposes. **(Please circle: YES or NO)**

_____ _____

Patient Signature or Authorized Signature** Date

_____

Relationship to Patient

_____

Witness Signature

**** If a patient is UNABLE to consent or is a MINOR, complete the following:**

- **Reason why patient is unable to consent:** _____
- **Patient** _____ **is a minor of (_____) years of age.**

HOME MEDICATION / RECONCILIATION LIST
LISTA DE TODOS SUS MEDICAMENTOS

This form (1) is a list of all home, over-the-counter and herbal medications the patient uses; (2) reconciles the patient's home medications with the practioner's order. This form is to be reviewed before each patient exam. Print below all of the patient's home medicationsprior to examination including over-the-counter and heral medications. All Medications will be continued unless otherwise indicated. All medications listed on this form are to entered into ExitCare by the nurse, and a copy be given to each patient.

Name	DOB	D#	ALLERGIES

PROHIBITED ABBREVIATIONS: A.S., A.D., A.U., IU, MS, MS04, MgS04, Q.D., Q.O.D., T.I.W., U, ug, leading zero, trailing zero

DA TE	MEDICATION NAME (PLEASE PRINT)	DOSE	INSTRUCTIONS	INITIALS

****HOME MEDICATION / RECONCILIATION LIST****

****LISTA DE TODOS SUS MEDICAMENTOS****

Por favor escribe todas las medicinas que toma; recetadas por su doctor, sin receta o medicamentos caseros.
Necesitamos que escriba todas las medicinas que toma diariamente.

Nombre		Fecha de Nacimiento	Alergias a alguna medicina?	
FECHA	NOMBRE DE MEDICINA (POR FAVOR ESCRIBE EN LETRA DE MOLDE)	DOSIS	INSTRUCCIONES	INICIALES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

MEHOP is required to provide you a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

****

I acknowledge that I have received a copy of MEHOP's Notice of Privacy Practices.

_____

Please print your name here (Patient/Parent/Legal Guardian)

_____

Signature (Patient/Parent/Legal Guardian) Date

****FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because: (Check one)

- o The patient refused to sign.
- o Due to an emergency situation, it was not possible to obtain an acknowledgement.
- o We weren't able to communicate with the patient.
- o Other (Please provide specific details)

_____

_____

_____

_____ _____

Employee Signature *Date*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

❒ Home Telephone _____

❒ O.K. to leave message with detailed information

❒ Leave message with a call-back number and name only

❒ Work Telephone _____

❒ O.K. to leave message with detailed information

❒ Leave message with call-back number and name only

❒ Cell Phone _____

❒ O.K. to leave message with detailed information

❒ Leave message with call-back number and name only

❒ Written Communication

❒ O.K. to mail to my home address

❒ O.K. to mail to my work address

❒ O.K. to fax to this number_____

❒ Other _____

_____

_____
Signature (Patient/Parent/Legal Guardian)

_____
Date

_____
Print Name (Patient/Parent/Legal Guardian)

_____
Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below will constitute and adequate record. Uses and Disclosures for treatment, payment and healthcare operations may be permitted without prior consent in an emergency.

For Office Use Only

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure / Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) check this box if the disclosure is authorized
(2) Type Code: T=Treatment Records P=Payment Information O=healthcare Operations
(3) Enter how disclosure was made: F=Fax P=Phone E=Email M=Mail O=Other

** Please initial 1-32
then sign & date

MATAGORDA EPISCOPAL HEALTH OUTREACH PROGRAM
PATIENTS' RIGHTS AND RESPONSIBILITIES

Updated 12/6/2017

As a Patient at MEHOP you have the right to:

Civil Rights

1. ___Be protected from discrimination. You have the right to receive services and treatment without discrimination on the basis of race, color, national origin, sex, age, religion, disability, ancestry, physical or mental handicap or disability, Vietnam era veteran status, or other grounds not permitted by applicable federal, state and local laws or regulations.

Payment for Services

2. _____Receive an explanation of the bill you receive for services.
3. _____Receive primary health care services, which are medically necessary, despite your inability to pay for these services. However, you are required to act in good faith and make payments for services.

Privacy

4. _____ Have your interviews, examinations and treatment in privacy. Your patient records (medical, dental, behavioral health, HIV, substance abuse) are also private. Only legally authorized persons may see your records unless you request in writing for us to show them to, or copy them for, someone else. A complete discussion of your privacy rights will be given to you along with this document and is named MEHOP's Notice of Privacy Practices. We ask that you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices sets forth the ways in which your patient records may be used or disclosed by MEHOP and the rights granted to you under the Health Insurance Portability and Accountability Act ("HIPAA"). If you have private insurance or are insured under Medicare or Medicaid, your insurer has the right to request patient records concerning a service that was billed to them by us.

Health Care

5. _____ Health care and treatment that is reasonable for your condition and within our capability, however, MEHOP is not an emergency care facility. You have a right to be transferred or referred to another facility for services that we cannot provide.
6. _____ 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.
7. _____ Information and explanations in the language you normally speak and in words that you understand.
8. _____ Participate in decisions about your treatment.
9. ____ Receive information regarding "Advance Directives." (An Advance Directive is instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity and appoints a person to make such decisions on their behalf.) If you do not wish to receive this information, or if is not medically advisable to share that information with you, we will provide it to your legally authorized representative.
   At this time would you like information about Advance Directives? ____Yes ____No
   If yes, additional information will be provided to you. If you state no, you may request information at another time.
10. _____ Receive information on how to appropriately use MEHOP's services.
11. _____ Refuse treatment or procedures, if you are an adult, to the extent permitted by applicable law and regulations. In this regard, you have the right to be informed of the risks, hazards and consequences of refusing such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed".
12. ____ Receive an appropriate assessment and pain management, as necessary, if you are in pain.

As a Patient at MEHOP you are responsible for:

Payment for Services

13. ____ Giving us accurate information about your present financial status and any changes in your financial status. We need this information to establish your fee and/or so we 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 200%, you will be charged a discounted fee.
14. _____ Payment or the arrangement of payment for all agreed fees for medical services, except for dental services, which are provided on a prepaid basis. Payment plans are made available for specific circumstances.
15. _____ Payment for services that you receive from another healthcare provider, including transportation to and received at Matagorda Regional Medical Center. You are responsible for payment arrangements for services provided by another provider or entity outside of MEHOP. This includes x-rays, mammograms, or bloodwork which are not MEHOP services.

Health Care

16. ____ Providing MEHOP with accurate, complete and current information about your health so that we can give you proper health care.
17. ____ Using MEHOP's services in an appropriate manner, which includes
    a. following our staff's instructions,
    b. making and keeping scheduled appointments and requesting a "walk-in" appointment only when necessary.
18. ____ Asking questions and expressing concern when you do not understand your treatment plan or what is expected of you.
19. ____ Being accountable for the consequences and outcome of refusing recommended treatment or procedures. If you refused 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).

Center Rules

20. _____ Being considerate of the rights and property of those around you.
21. _____ Being respectful of other patients, visitors, and staff.
22. _____ Understanding that MEHOP is a teaching clinic, therefore supervised students will be helping to care for you.
23. _____ Being accountable for the supervision and safety of children you bring with you to MEHOP. You are responsible for your children's safety and the protection of other patients and our property. We are not responsible for children left unattended. Should any damages occur, you may be responsible for reimbursement of cost to repair or replace.
24. _____Keeping your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you have more than three (3) missed scheduled appointments, you will no longer be able to make scheduled appointments and will only be able to be seen as a walk in. Please remember that transportation is a scheduled appointment.

25. _____ Arriving to your appointment at the time that was scheduled for you. Tardiness causes delay in treating other patients and is therefore disrespectful to our staff and to our other patients. If you arrive more than 15 minutes past your scheduled appointment time, you are not guaranteed to be seen by your provider. After 15 minutes past your scheduled appointment time, you will be given the choice to reschedule your appointment or to be seen as a walk in.

Complaints

26. ____If you are not satisfied with our services, please tell us. We want suggestions, so we can improve our services. You may request a Client Suggestion/Complaint Form to document your concerns. You shall receive a response from MEHOP by mail or phone regarding the outcome of your complaint or suggestion. If you are not satisfied with how the complaint is handled, you may contact MEHOP's Board of Directors.
27. _____You cannot be punished for filing a complaint, and we will continue to see you as a patient.

Termination

28. ____If we decide to terminate our relationship with you, you have a right to advance notice that explains the reason for the decision, and you will be given thirty (30) days to find other health care services. If you are terminated as a patient, you will be terminated from all MEHOP services.
29. ____ If you have threatened the safety of our staff and/or other patients, MEHOP will stop treating you immediately, and without written notice.
30. ____ You have a right to receive a copy of MEHOP's Patient Termination Policy and Procedure. Reasons to terminate may include: (1) failure to obey MEHOP rules, (2) intentional failure to report accurate financial information, (3) intentional failure to provide accurate health information, and (4) intentional failure to follow medical advice.
31. _____If we decide to stop treating you as a patient, you have a right to appeal the decision to the Board of Directors or through the courts. Unless there is an emergency, we will not continue to see you as a patient while you are appealing the decision.

Assignment of Insurance Benefits to Provider

32. ____ I hereby request payment and assign any benefits due me under the terms of any policy or policies and/or under Title XV111 of the Social Security Act that may cover professional services rendered to the above name mentioned assignee

Signature _____ Date _____

MEHOP
Matagorda Episcopal Health | Outreach Program
101 Avenue F North
Bay City, Texas 77414

Name:_____ **Patient #**_____

Date of Birth: _____/_____/_____ **(For *Office Use Only*)**

Date: _____

Please circle your income bracket. If your income is circled in any column but the far right you may qualify for reduced fees.

Total # of Individuals in Household	Monthly/Yearly Income Equal or Less Than	Monthly/Yearly Income In This Range	Monthly/Yearly Income In This Range	Monthly/Yearly Income In This Range	Monthly/Yearly Income In This Range	Monthly/Yearly Income Equal or Greater Than
1	$990/$11,880	$990.01 to $1,237.50/ $11,880.12 to $14,850	$1,335 to $1,485/ $16,020 to $17,820	$1,485.01 to $1,732.50/ $17,820.12 to $20,790	$1,732.51 to $1,980/ $20,790.12 to $23,760	$1980.01/$23,760.12
2	$1335/$16,202	$1335.01 to $1668.75/ $16,020.12 to $20,025	$1,668.76 to $2,002.50/ $20.025.12 to $24,030	$2,202.51 to $2,336.25/ $26,430.12 to $28,035	$2,336.26 to $2,670/ $28,035.12 to $32,040	$2670.01/$32,040.12
3	$1680/$20,160	$1680.01 to $2100/ $20,160.12 to $25,200	$2,100.01 to $2,520/ $25,200.12 to $30,240	$2,520.01 to $2,940/ $30,240.12 to $35,280	$2,940.01 to $3,360/ $35,280.12 to $40,320	$3360.01/$40,320.12
4	$2025/$24,300	$2025.01 to $2531.25/ $24,300.12 to $30,375	$2,531.26 to $3,037.5/ $30,375.12 to $36,450	$3,037.51 to $3,543.75/ $36,450.12 to $42,525	$3,543.76 to $4,050/ $42,525.12 to $48,600	$4050.01/$48,600.12
5	$2370/$28,440	$2370.01 to $2962.5/ $28,440.12 to $35,550	$2,962.51 to $3,555/ $35,550.12 to $42,660	$3,555.01 to $4,147.5 /$42,660.12 to $49,770	$4,147.51 to $4,740/ $49,770.12 to $56,880	$4740.01/$56,880.12
6	$2715/$35,580	$2,715.01 to $3,393.75/ $32,580.12 to $40,725	$3,393.76 to $4,072.5/ $40,725.12 to $48,870	$4,072.51 to $4,751.25/ $48,870.12 to $57,015	$4,751.26 to $5,430/ $57,015.12 to $65.160	$5430.01/$65,160.12
7	$3060/$36,720	$3,060.01 to $3,825/ $36,720.012 to $45,900	$3,825.01 to $4,590/ $45,900.12 to $55,080	$4,590.01 to $5,355/ $55,080.12 to $64,260	$5,355.01 to $6,120/ $64,260.12 to $73,440	$6120.01/$73,440.12
8	$3405/$41,400	$3,405.01 to $4,256.25/ $40,860.12 to $51,075	$4,256.26 to $5,107.5/ $51,075.12 to $61,290	$5,107.51 to $5,958.75/ $61,290.12 to $71,505	$5,958.76 to $6,810/ $71,505.12 to $81,720	$6810.01/$81,720.12

On _____[DATE], I do/do not (Please circle) want to participate in the eligibility process of Matagorda Episcopal Health Outreach Program (MEHOP). I understand that by refusing to participate that I am stating that at least one of the following applies to me:

- I have insurance to cover the visit
- I am willingly choosing not to use my insurance
- My income is over 200% of poverty

By refusing to participate in the eligibility process, I completely understand that I will be charged the full fee at the time of payment.

_____

Signature of Patient

HOUSEHOLD ASSESSMENT