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
		o Lesbian, Gay, Homosexual o Straight or Heterosexual o Bisexual o Something else o Don't know o Choose not to disclose	o Male o Female o Transgender Male [F-to-M] o Transgender Female [M-to-F] o Other o Choose not to disclose	o M o 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	o Not Homeless o Doubling Up o Homeless Shelter o Other o Street o Unknown o 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

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

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 become 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.**

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

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

** Please initial 1-15 then sign & date

MATAGORDA EPISCOPAL HEALTH OUTREACH PROGRAM
NOTICE OF FINANCIAL RESPONSIBILTY

Private Insurance/Medicaid/Medicare:

1._____ I understand that it is my responsibility to show my insurance card at registration or check-in so that MEHOP can verify my benefits. I further acknowledge that if I fail to notify the receptionist about changes to my coverage, I will be responsible for any past or present charges.

2._____ If my plan requires a primary care provider (PCP), I understand that the choice of a PCP is my decision. I understand it is my responsibility to obtain a referral prior to my scheduled appointment from my PCP if it is not a MEHOP provider. I acknowledge that if I fail to obtain a referral from my PCP or if my PCP is not a MEHOP provider than I will be fully responsible for the cost of services delivered by MEHOP.

3._____ I understand that even if I have an insurance plan that I am responsible at the time of service for all co-payments/deductibles and costs of services and treatments provided to me by MEHOP that are not covered by my insurance plan. If I am unable to pay, I understand that it is my responsibility to contact the billing department at 979.245.2008 ext 309 to set up a payment plan.

4._____ I authorize MEHOP to furnish to Medicaid, Medicare and/or third-party insurance coverage all of the necessary medical information, including my HIV status, to process my claim. I also hereby assign to MEHOP all payments received from Medicaid, Medicare and/or a third-party insurer for services and treatments provided to me by MEHOP.

Eligibility for Discounted Services:

5._____ I understand that MEHOP provides access to services without regard for a person's ability to pay for such services.

6._____ I understand that to be eligible for discounted programs, I am required to complete the process for the Sliding Fee Program. I understand that it is my responsibility to schedule an appointment with an Eligibility Specialist and to present the necessary documentation on Household Income and Family Size for the determination of my eligibility and pay category. I further understand that I must have completed the eligibility requirements prior to my scheduled appointment.

7._____ I understand that even if I qualify for the Sliding Fee Program that I am responsible at the time of service for the total cost of services and treatments provided to me by MEHOP. If I am unable to pay, I understand that it is my responsibility to contact the billing department at 979.245.2008 Ext 309 to set up a payment plan prior to my scheduled appointment.

8._____ I understand that if I qualify for a grant funded program such as the Primary Health Care (PHC) or Breast and Cervical Cancer Screener (BCCS), these resources are payers of last resort. Payers of last resort may not continue my eligibility if I currently or in the future have Medicare, Medicaid and/or third-party insurance coverage. I agree to immediately report any changes in my financial status and/or insurance coverage. If I fail to appropriately report these changes and if those changes result in my ineligibility for those programs, I understand that I am fully responsible for all total cost of services that were received by myself or dependent when I was ineligible for those programs.

Self-Pay (Out-of-Pocket):

9._____ I understand that all services that I have elected to pay out-of-pocket (self-pay) must be paid in full on or before the date of service. I further understand that by electing to be billed as "self-pay" that MEHOP will not be billing or accepting any insurance carrier for services provided. I acknowledge that MEHOP will not submit billing to my insurance carrier for previously completed self-pay visits even if I choose to revoke my self-pay status later.

** Please initial 1-15 then sign & date

MATAGORDA EPISCOPAL HEALTH OUTREACH PROGRAM
NOTICE OF FINANCIAL RESPONSIBILTY

10._____ I understand that the self-pay rates at MEHOP follow Medicare standards and are subject to changes or increases. I further understand that the self-pay rates will be updated annually to reflect industry pricing.

11._____ I understand that the office visit fee does not include the fees for testing and/or procedures. I understand that I will be responsible for supplemental fees for any additional service I receive during my office visit including but not limited to biopsies, blood draws, and/or injections.

12._____ I understand by electing to pay out-of-pocket for any MEHOP service that those services will no longer be eligible to be submitted to my insurance carrier. I understand that I, myself, or a third party cannot submit a claim to my insurance carrier for any MEHOP service that were paid out-of-pocket after all compensation for those services has been rendered to MEHOP by myself or a third party.

Additional

13._____ I understand that the failure of myself or my dependent to utilize MEHOP services for more than three consecutive years will result in my or my dependent's status being changed to "new patient". I understand that my dependent or I will be treated as a new patient upon our return. I further understand that I will be charged a higher initial office visit to reestablish myself or my dependent as a patient.

14._____ I understand that I am responsible for all ancillary services including but not limited to laboratory or pathology testing. Since these services are not provided by MEHOP, I understand that I have the right to choose an ancillary service provider. I further understand that I must contact the ancillary service provider directly for payment, pricing, and other inquires.

15._____ I understand if I request medical records that I will be responsible for a charge for medical records that shall be no more than $25 for the first twenty pages and $0.55 per page for every copy thereafter.

Please check which of the following applies to you/your dependent:

_____ I am covered by an insurance company that may or may not be In Network.

_____ I am covered by a contracted insurance company, but I do not wish MEHOP to submit a claim to my carrier. Instead, I freely choose to self-pay for all services.

_____ I do not have health insurance, or my insurance company is not In Network. Instead, I freely choose to self-pay for all services.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

** Please initial 1-33
then sign & date

MATAGORDA EPISCOPAL HEALTH OUTREACH PROGRAM
PATIENTS' RIGHTS AND RESPONSIBILITIES

Updated 03/24/2020

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.
13. ____ You have the right to schedule an online or telephone appointment and be seen with one of our MEHOP Providers from the safety of your own home during emergency or natural disaster situations. i.e. Telemedicine or Telehealth

As a Patient at MEHOP you are responsible for:

Payment for Services

14. ____ 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.
15. _____ 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.
16. _____ 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

17. ____ Providing MEHOP with accurate, complete and current information about your health so that we can give you proper health care.
18. ____ 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.
19. ____ Asking questions and expressing concern when you do not understand your treatment plan or what is expected of you.
20. ____ 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

21. _____ Being considerate of the rights and property of those around you.
22. _____ Being respectful of other patients, visitors, and staff.
23. _____ Understanding that MEHOP is a teaching clinic, therefore supervised students will be helping to care for you.
24. _____ 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.

25. _____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.
26. _____ 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

27. ____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.
28. _____You cannot be punished for filing a complaint, and we will continue to see you as a patient.

Termination

29. ____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.
30. ____ If you have threatened the safety of our staff and/or other patients, MEHOP will stop treating you immediately, and without written notice.
31. ____ 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.
32. _____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

33. ____ 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

Nombre:_____ **Patient #**_____

Fecha de Nacimiento: _____/_____/_____ **(Para Uso de la Oficina)**

Fecha: _____

Por favor circule el bracket de ingresos en el que cai. Si su ingreso está marcado en cualquier columna excepto en el extremo derecho, es posible que califique para tarifas reducidas.

# Total de individuos en casa	Ingresos Mensual/ Anual igual o menos de	Ingresos Mensual/Anual en este grupo	Ingresos Mensual/ Anual en este grupo	Ingresos Mensual/ Anual en este grupo	Ingresos Mensual/ Anual en este grupo	Ingresos Mensual/ Anual igual o mas de
1	$1063/ $12,760	$1,063.01 to $1,329/ $12,760.01 to $15,950	$1,329.01 to $1,595/ $15,950.01 to $19,140	$1,595.01 to $1,861/ $19,140.01 to $22,330	$1,861.01 to $2,127/ $22,330.01 to $25,520	$2,127.01/ $25,520.01
2	$1437/ $17,240	$1,437.01 to $1,796/ $17,240.01 to $21,550	$1,796.01 to $2,155/ $21,550.01 to $25,860	$2,155.01 to $2,514/ $25,860.01 to $30,170	$2,514.01 to $2,873/ $30,170.01 to $34,480	$2,873.01/ $34,480.01
3	$1810/ $21,720	$1,810.01 to $2,263/ $21,720.01 to $27,150	$2,263.01 to $2,715/ $27,150.01 to $32,580	$2,715.01 to $3,168/ $32,580.01 to $38,010	$3,168.01 to $3,620/ $38,010.01 to $43,440	$3,620.01/ $43,440.01
4	$2183/ $26,200	$2,183.01 to $2,729/ $26,200.01 to $32,750	$2,729.01 to $3,275/ $32,750.01 to $39,300	$3,275.01 to $3,821/ $39,300.01 to $45,850	$3,821.01 to $4,367/ $45,850.01 to $52,400	$4,367.01/ $52,400.01
5	$2557/ $30,680	$2,557.01 to $3,196/ $30,680.01 to $38,350	$3,196.01 to $3,835/ $38,350.01 to $46,020	$3,835.01 to $4,474/ $46,020.01 to $53,690	$4,474.01 to $5,113/ $53,690.01 to $61,360	$5,113.01/ $61,360.01
6	$2930/ $35,160	$2,930.01 to $3,663/ $35,160.01 to $43,950	$3,663.01 to $4,395/ $43,950.01 to $52,740	$4,395.01 to $5,128/ $52,740.01 to $61,530	$5,128.01 to $5,860/ $61,530.01 to $70,320	$5,860.01/ $70,320.01
7	$3303/ $39,640	$3,303.01 to $4,129/ $39,640.01 to $49,550	$4,129.01 to $4,955/ $49,550.01 to $59,460	$4,955.01 to $5,781/ $59,460.01 to $69,370	$5,781.01 to $6,607/ $69,370.01 to $79,280	$6,607.01/ $79,280.01
8	$3677/ $44,120	$3,677.01 to $4,596/ $44,120.01 to $55,150	$4,596.01 to $5,515/ $55,150.01 to $66,180	$5,515.01 to $6,434/ $66,180.01 to $77,210	$6,434.01 to $7,353/ $77,210.01 to $88,240	$7,353.01/ $88,240.01

El día de _____ [fecha], yo deseo/no deseo (circulé por favor) participar en el proceso de elegibilidad de Matagorda Episcopal Health Outreach Program (MEHOP). Entiendo que al negarme a participar estoy diciendo que al menos uno de los siguientes se aplica a mí:

- Tengo un seguro para cubrir la visita
- Yo elijo voluntariamente para no utilizar mi seguro
- Mis ingresos son superior al 200% de pobreza

Al negarme a participar en el proceso de elegibilidad, entiendo perfectamente que me cobrarán la tarifa completa en el momento del pago.

_____

[Firma del paciente]

EVALUACION DE HOGAR

MATAGORDA EPISCOPAL HEALTH OUTREACH PROGRAM
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.

MEHOP is required by law to maintain the privacy of Protected Health Information and to provide individuals with notice of our legal duties and privacy practice with respect to Protected Health Information. This document is being provided to you in fulfillment of these obligations.

Protected Health Information, or PHI as it may be referred to in this document, is information about your identity (E.G. Your name, address, social security number, etc), your past, present, or future medical or mental condition (e.g. History of illnesses, current medications, future appointments, etc), past, present or future related health care services (e.g. procedures performed, lab tests ordered, etc.) and past present, or future payment for medical services (e.g. insurance carrier, deductibles, payments made, etc.)

MEHOP reserves the right to amend or change its practices, policies, or procedures with regards to PHI at any time, and to make such changes effective for all PHI' in our possession, including any PHI that may have been created or received prior to such changes. In the event of such a change MEHOP will post a new revision of this Notice in our facility and make a copy of it available to you upon request.

MEHOP is required to make sure that all times our office operates in a manner that is consistent with the provisions of the most current revision of this notice. If at any time you believe MEHOP has acted in a manner inconsistent with our most current Notice of Privacy Practices, or you feel your rights to privacy have been violated in any way, you are entitled to file a complaint with this office of with the Secretary of Department of Health and Human Services. To file a complaint with this office, or for further information with regards to this notice or MEHOP' privacy practices, please contact the CEO at (979) 245-2008. MEHOP will not retaliate in any way against any individual who files a complaint wither with this office or with the Secretary of the Department of Health and Human Services.

Use or Disclosure of PHI for Treatment, Payment, and Operations

MEHOP may use or disclose your PHI without your authorization for your treatment, to receive payment for any services rendered, and for the normal operations of this clinic. For example:

Treatment – We may use or disclose your PHI in coordinating treatment among our staff or with other providers, such as primary physician or specialist.

Payment – We may use or disclose your PHI to your insurance company as required to obtain payment for any services that have been rendered.

Operations –We may use or disclose your PHI for quality assurance purposes, as part of employee performance evaluation, or to help train new employees.

Other uses or Disclosures of PHI Permitted or Required without Your Authorization

MEHOP may also use or disclose you PHI without your written authorization in the following situations:

- **To You:** MEHOP may disclose your PHI to you:
- **Incident to an Otherwise Permitted Use or Disclosure:** Accidental disclosures of your PHI that occur in the course of making an otherwise permitted use or disclosure are permitted as long as MEHOP has taken appropriate safeguards to try to protect the confidentiality of your PHI, and has satisfied the requirements to use the mi8nimum amount of PHI necessary for any permitted use or disclosure of your PHI;
- **Appointment Reminders:** MEHOP may use or disclose your PHI to contact you to provide appointment reminders, information about treatment alternatives that may apply to you, and other health related services or benefits that may be interest to you;
- **Disclosure to Others Involved in Your Care:** PHI may be used or disclosed to family members or others designated by you as being involved in your care. This may include notifying such individuals who are waiting for you while you are being treated in our facility, or leaving telephone messages concerning your condition, your treatment, or your account, on answering machines or with family members. Such disclosures will be limited to minimum information necessary or to the extent of the person's involvement in your care. You have the right to object to such disclosures. Please notify your physician's nurse if you wish to object;
- **Disaster Relief/Response:** MEHOP may disclose your PHI to public or private entity that is authorized by law or by its charter to assist with disaster relief efforts (for example, the Red Cross);
- **Required by the Secretary of Health and Human Services:** PHI may be used or disclosed to demonstrate our compliance with the Health Insurance Portability Accountability Act, if so directed by the Secretary;
- **Required by Law:** PHI may be used or disclosed to the extent required by law such as for the purposes of reporting abuse or neglect, in response to a judicial or administrative proceeding, or as may be required by law enforcement purposes. Such disclosures will be limited to the minimum information required by the law;

- **For Public Health Activities:** PHI may be used or disclosed for public health activities such as: preventing or controlling disease, injury, or disability; reporting child abuse or neglect; reporting necessary for the Food and Drug Administration (FDA); to notify someone who may have been exposed to a communicable disease; or reports to employers about work related injuries or work place surveillance;
- **To Report Victims of Abuse, Neglect, or Domestic Violence:** PHI may be used or disclosed to agencies authorized by law to receive reports about abuse, neglect, or domestic violence;
- **For Health Oversight Activities:** PHI may be used or disclosed to a health oversight agency for activities authorized by law, including audits, licensure activities, investigations, etc;
- **Judicial or Administrative Proceedings:** PHI may be used or disclosed in response to an order of the court or administrative tribunal, subpoena, discovery request, or other lawful process;
- **For Law Enforcement:** In certain circumstances, PHI may be used or disclosed to law enforcement officials for law enforcement purposes;
- **To Coroners and Funeral Directors:** PHI about decedents may be used or disclosed to a coroner, medical examiner, or funeral directors to allow them to carry out their duties as authorized by law;
- **For Organ and Tissue Donation:** PHI may be used or disclosed to organizations authorized in the procurement, banking, or transplantation of cadaveric organs, or tissues;
- **For Research:** PHI may be used or disclosed for research studies that have been approved by an institutional review board as having established the necessary protocols to protect the privacy of PHI;
- **To Prevent an Imminent Threat to a Person or the Public:** PHI may be used or disclosed in situations where it is believed in good faith to be necessary to prevent or diminish the threat of imminent harm to the health or safety of a person or the public;
- **For Specialized Government Functions:** PHI may be used or disclosed in very special circumstances involving; armed forces personnel; national security or intelligence activities; as necessary for the protection of the President or other authorized person; to determine medical suitability for State Department services; concerning inmates of a correctional institution; government programs that provide public benefits;
- **For Worker's Compensation Programs:** PHI may be used or disclosed as required to comply with worker's compensation and other similar programs;
- **To Business Associates:** MEHOP may disclose your PHI to a Business Associate of ours (a third party) whom we have contract with to perform a function on our behalf (such as billing or collections), as long as our contract requires that our Business Associate safeguard your PHI and keep it confidential

Uses or Disclosures of PHI That Require Your Written Authorization

Any other use or disclosure of your PHI, not previously identified, will only be made upon receipt of your written authorization. Such authorizations will be requested by MEHOP as needed. Your receipt of care may not be conditioned upon your approval of an authorization unless the sole reason for health care is to provide PHI to a third party (e.g. Physical examination for insurance eligibility), or treatment is part of a research study requiring your authorization.

You are entitled to revoke any authorization at any time, provided the revocation is in writing and except to the extent that MEHOP has already taken action in reliance on your authorization, or if the authorization was a condition of obtaining insurance coverage. To revoke an authorization, please submit your written request to your physician.

Your Rights with Respect to Your Protected Health Information

Right to Request Restrictions: You have the right to request reasonable restrictions on the use or disclosure of your PHI including uses and disclosures for treatment, payment, and operations. MEHOP is not obligated to honor your requests; however, we will attempt to make reasonable accommodations. To request a restriction, please see the Front Desk for the proper form.

Right to Confidential Communications: You have the right to request confidential communications by alternative means or at alternative locations. For example, you may request that we not contact you by phone, or not at your work location. MEHOP will accommodate reasonable requests. To request confidential communications, please see the Front Desk for the proper form.

Right to Inspect and Copy your Protected Health Information: With some exception, you have the right to inspect or copy your PHI that exists in a designated record set, for as long as the information is in the possession of MEHOP. To inspect or copy your PHI, please see the Front Desk for proper form.

Right to Amend Your Protected Health Information: You have the right to request an amendment be made to your PHI that exists in a designated record set, for as long as that information is in the possession of the MEHOP. If you would like to request an amendment to your PHI, please see the Frond Desk for the proper from.

Right to Receive an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your PHI that were made with certain exceptions, within the six (6) years prior to the date of request. If you would like to receive an accounting of disclosures, please see the Frond Desk for the proper from.

Right to Receive Copies of This Notice of Privacy Practices: You have the right to receive a paper copy of our most current Notice of Privacy Practices at any time. If you would like to receive a new copy, please ask the Front Desk