

HILL COUNTRY COMMUNITY CLINIC CONSENT FOR MEDICAL/DENTAL TREATMENT

Patient Name: _____

ADULT: I hereby authorize Hill Country Community Clinic and all persons acting as agents thereof, as well as all medical/dental personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic, medical and dental treatment to me.

SIGNED: _____ Date: _____

MINOR: I, as the parent/guardian (circle one) of the above named minor, hereby authorize Hill Country Community Clinic medical/dental personnel to whom said minor is referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic, medical and dental treatment to said minor. This consent shall remain in force until a written revocation is filed at the clinic.

SIGNED: _____ Date: _____

(parent/guardian)REV. 1/13

PATIENT REGISTRATION (please print clearly)

PATIENT INFORMATION Name must match what is on your insurance card or ID or we may not be able to bill.

LAST NAME: _____ FIRST: _____ MI: _____

ANY ALIASES: (Such as Maiden Name or Prev. Married) _____

MAILING ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME ADDRESS (if different) _____ CITY: _____ ST: _____ ZIP: _____

HOMELESS: SHELTER TRANSITIONAL HOUSING DOUBLED UP STREET OTHER

PHONE HOME: _____ WORK: _____ CELL: _____

MESSAGE#: _____ EMAIL ADDRESS: _____

Preferred Method to Contact: (Please Circle 2) HOME PHONE WORK CELL MESSAGE PHONE EMAIL TEXT

BIRTHDATE: _____ SEX: F M SSN# _____ MARITAL STATUS: S M D W

EMERGENCY CONTACT: _____ PHONE _____ RELATIONSHIP _____

PARENT or GUARDIAN (if patient is minor) OR SPOUSE INFORMATION

PARENT OR SPOUSE NAME: _____ SSN# _____

ADDRESS (if different than patient): _____ CITY: _____ ZIP: _____

PHONE (if different than patient): HOME: _____ WORK: _____

CELL: _____ BIRTHDATE: _____ SEX: F M MARITAL STATUS: S M D W

PATIENT DEMOGRAPHICS: To enable us to qualify for our grants and meet our Federal and State reporting requirements, along with possibly allowing us to offer more services, we must ask for the following information. Your answers are strictly confidential. Your name will not be used. Please Circle or Check the appropriate box.

LANGUAGE SPOKEN IN YOUR HOME: ENGLISH SPANISH OTHER _____

RACE (select more than one if appropriate) WHITE BLACK NATIVE HAWAIIAN PACIFIC ISLANDER
 ASIAN AMERICAN INDIAN/ALASKAN NATIVE

ARE YOU HISPANIC OR LATINO? YES NO

ARE YOU AN AGRICULTURAL (FARM) WORKER?: YES NO IF YES, ARE YOU SEASONAL OR MIGRANT

ARE YOU A VETERAN?: YES NO

WHAT IS YOUR FAMILY SIZE: _____ WHAT IS YOUR FAMILY'S MONTHLY INCOME: _____

HOW YOU FOUND US: Word of Mouth Radio/TV Website/Internet Newspaper
Nickel Doctor / Dentist Bulletin Board Community / County Agency

OTHER: _____

The preceding information is true to the best of my knowledge.

SIGNATURE: _____ DATE: _____

12/17/2013

Hill Country Community Clinic

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. Our Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to provide you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this Notice.

Patient Acknowledgement of Receipt/Opt Out

I have been provided a copy of the health center's Notice of Privacy Practices

I have been offered, but have chosen not to receive copy of the health center's Notice of Privacy Practices

Patient's Signature

Date

Signature of Parent or Patient's Representative (if applicable)

Date

Description of Legal Authority to Act on Behalf of Patient

Date

Hill Country Community Clinic Patient Financial Agreement

- You are responsible for all charges incurred on your account. Payment is expected at time of service for fees that have been determined to be the responsibility of the patient.
- **Medi-Cal/CMSP:** Hill Country accepts Medi-Cal and CMSP. A current card must be presented at each visit.
- **Medicare :** We are required to collect additional information to determine coverage.
- **Insurance Plan:** We are contracted with many but not all insurance carriers. If we don't appear on your insurance carriers provider list this may affect how your insurance plan pays for your care and you may be required to pay at time of service.
- **Payment Methods:** Hill Country Community Clinic accepts cash, personal checks, debit cards, Visa and MasterCard. A \$10.00 service fee will be charged for bounced checks.
- A sliding fee discount is available for patients who are unable to afford care

✕

Please Sign Here

Date

Insurance information and authorizations

Insurance Company Name: _____

ID #: _____ Group #: _____

Policy holder Name: _____

Relationship to Patient: Self Spouse Parent Other

Policy Holder Address: _____

Policy Holder Date of Birth _____

- I hereby authorize the release of any and all information, acquired in the course of my examination/treatment as required by my insurance carrier.
- I hereby authorize and request the payment of benefits be sent directly to Hill Country Community Clinic for services rendered.
- These assignments will remain in effect until revoked by me in writing. A copy of this agreement is considered as valid as the original.

Authorizing signature and date

Patient Name _____

Responsible Party _____

Signature of Responsible Party

Date

For Office Use Only:

Patient I.D: _____

D.O.B: _____

Effective Dates: _____ To: _____

Scanned by : _____

Multiple Scans: (1X) (2X) (3X) (4X) (5X)

Hill Country Health and Wellness Center Sliding Fee Scale discount program

Hill Country (HCCC) offers a "Fee Discount" program. Many individuals qualify for the Sliding Fee Scale Program and can receive low cost health services. To qualify, an individual must meet Federal family income criteria.

Requirements of the Sliding Fee Scale program:

1. You must complete the Financial Information/Program Application form annually to determine your eligibility and discount. This information includes:
 - a. Your total household income from all income sources before taxes
 - b. Number of family members living in your household
2. At our discretion, we may require proof of information stated on the Sliding Fee Scale Program application.
3. Your discount may vary if your income changes.
4. Your fee is due at each visit.
5. Sliding Fee Scale payments are refundable whenever HCCC receives payment from the insurance for that date of service.
6. Services offered under the HCCC Sliding Fee Scale program are limited to those deemed medically necessary by appropriate Clinic staff. Cosmetic and elective health services do not qualify for the program.

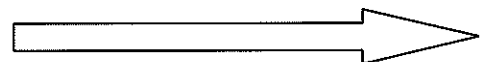
Important Note: Some services may include additional charges and may not be subject to the discount.

Medical Service Discounts and Exclusions

1. **LAB SERVICES:** If your health care provider orders lab work, (blood or urine test, etc.), you will get a discount if they are basic lab tests performed at HCCC or at any LabCorp facility. There is a fee for all lab charges, payable at the time of the visit. It will be your responsibility to pay 100% of the charge if any other lab is used or for any lab work that must be sent away for testing. The laboratory staff can tell you what the tests will cost.
2. **X-RAY SERVICES:** If your health care provider orders x-rays, you will get a discount if they are performed at Medical Doctors Imaging (MDI) or on site at Hill Country and are paid for at the time of service.
3. **SPECIAL STUDIES:** Your health care provider may order special diagnostic studies (such as a sonogram or CT). You will be responsible for 100% of these charges and must make arrangements to pay the facilities that provide them.

Please let us know if you have any questions about our programs or services. We are here to assist you.

Please complete and sign the back side of this form



01/28/2013

Hill Country Health & Wellness Center Blue Card Program Application for Health Services Discount

Hill Country Clinic offers many discounts for health services. You must complete this form to apply for these discounts. All information will be kept strictly confidential. **Payment is due at time of service.**

Patient Name: _____ Patient Date of Birth: _____ Date: _____

Responsible Party: _____ Date of Birth: _____ ACCT#: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell: _____

PT ID	House Hold Family Members (include self)	Relationship	Date of Birth	Age	Gross Monthly Income	Name of Current Insurance Plan

List any additional family members on the additional page if needed.

Definition of House Hold Members for Hill Country: All family members (Self, spouse, domestic partner and children) living in your household and supported by the family income. This would also include any children under the age of 21 who are away at school who are being claimed as tax dependents. To qualify additional household members (such as an older parent), you must be claiming them on your tax return. People residing with you temporarily, while looking for housing, or during transitions in their lives, should apply for the sliding scale on their own as individuals.

Definition of Gross Monthly Income for Hill Country: List the source of any earned or unearned income and the amount (before taxes or deductions). This is to include income from employment, tips, commissions, pensions, social security, child and/or spousal support, ongoing insurance payments, disability, Veterans Affairs, unemployment benefits, etc. For self-employment you would include all net profit. When listing a House Hold Member who has any of the above Incomes then you must list their income.

You must inform HCCC if your income changes during the time you are receiving these discounts. I state that the information I provided above is true and accurate to the best of my knowledge. I understand that deliberately providing false information may void this application and any related discounts.

Applicant's Signature: _____ Date: _____

OFFICE USE ONLY: <input type="checkbox"/> DENIED: <input type="checkbox"/>	PT REFUSED APPLICATION <input type="checkbox"/>	FAMILY SIZE: _____
TOTAL HOUSEHOLD INCOME: _____	(Weekly Pay X 4.33, Every 2 Weeks' Pay X 2.167, Twice A Month Pay X 2=Monthly)	CATEGORY: A B C
REVIEWED BY(Signature): _____	DATE REVIEWED: _____	EFFECTIVE DATE: _____ RENEW DATE: _____

HILL COUNTRY COMMUNITY CLINIC
Behavioral Health Services

GENERAL INFORMATION AND CONSENT FOR TREATMENT

Welcome to Hill Country Community Clinic. The decision to seek professional help for a personal or family problem is often a difficult one. We respect your courage in this decision we look forward to working with you. Our behavioral health staff includes professionals trained to evaluate and provide counseling and psychotherapy to individuals, families, and groups. The purpose of these services is to help you or your family address problems and make changes that will enable you to achieve more satisfaction and success in your various life roles and relationships.

The following guidelines will help to establish a framework for your relationship with your therapist. If you have any questions about anything cited in these guidelines, please discuss them with your therapist.

WHAT TO EXPECT

Risks and Benefits: Participating in therapy can have a variety of risks and benefits. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings, such as sadness, guilt, anger, loneliness and helplessness. Attempting to resolve issues between relationship partners, family members, and other individuals can also lead to high levels of discomfort and may result in changes that were not originally intended. On the other hand, psychotherapy can also result in a variety of benefits to you, including a better understanding of your personal goals and values, a resolution of the specific concerns that led you to seek therapy, improved interpersonal relationships, and significant reductions in feelings of distress. There are no guarantees of what you will experience, but your therapist will work with you to ensure that your treatment is as beneficial as possible.

Length of Therapy: The first few sessions typically involve an evaluation of your needs. During this time you will both decide if the therapist is the best person to provide the services you need. By the end of the evaluation sessions, your therapist will be able to offer you some first impressions of what your work will include and a treatment plan, including an estimated length of time for treatment. This will enable you to make an informed decision about your participation as therapy can involve a large commitment of time, money and energy. You should be sure that you are willing to make such a commitment. If you are uncomfortable with any of your therapist's practices, we encourage you to speak directly with him/her about your concerns. Your therapist will take your concerns seriously and respond with care and respect. If your doubts persist, we will be glad to refer you to another mental health professional.

AVAILABILITY

Appointments: Appointments may be scheduled Monday through Friday during regular business hours. If you need to speak to your therapist between sessions, the front office staff answers the phone and they can connect you with your therapist or take a message. Therapists will not answer phone calls when they are in session, but will call back as soon as possible. Telephone calls should be brief, as they are not meant to take the place of an appointment. If your call is to adjust an appointment time, please speak to the front office staff.

Emergencies: If you are experiencing an emergency, you must be willing to accept responsibility for your own safety. This may include going to your local hospital emergency room, contacting another health care professional that you may be working with, calling Help Line at 1-800-821-5252 or calling 911. If your therapist will be unavailable for an extended time, he/she will provide you with the name of a colleague to contact during crises.

YOUR RESPONSIBILITIES

Therapy Appointments: Appointments generally occur on a regular or routine basis, usually weekly or every other week, for 45 minutes. In a sense, you have a contract whereby you have the exclusive use of your therapist's time for your scheduled appointment. *In the event that you are unable to keep your appointment, we ask that you cancel as soon as possible so that the session time will be available for someone else.* If you are late for your appointment, you will be given the remainder of the time period that was originally scheduled. If you would like to discuss an issue that may require longer than the time allotted, please request a longer appointment.

(continued on other side)

Physical Health and Referrals: Your physical health can have a profound influence on your emotional well being. For this reason, you are strongly encouraged to follow up on referrals for any additional services your therapist suggests. It is recommended that you have a physical examination to rule out any physical conditions causing or exacerbating your current emotional state. Similarly, it is your responsibility to keep current with your physical condition by receiving medical check-ups and/or care. It is also your responsibility to inform your therapist of any medications you are taking or changes in your medication, especially those involving psychotropic medications.

Payment for Services: We accept many forms of insurance, including Medi-Cal and Healthy Families, and offer a sliding scale fee to accommodate qualified clients who are uninsured. The fee is based on total household income and number of dependents. A 10% discount is given for persons who pay at the time of service. Payment can be made by cash or check. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Our office staff can help you obtain the benefits to which you are entitled. However, you are responsible for payment of copayments or fees not covered by your insurance. Therefore, it is important that you learn about the mental health coverage you have with your insurance company. Note: Managed Health Care plans often require you to obtain authorization from them before you schedule an appointment for mental health services.

OTHER INFORMATION

Physical Touch and Sexual Contact: For some people, talking about sexual thoughts or feelings may be a part of therapy, but a sexual relationship between a client and psychotherapist is never okay. Knowing this helps many people feel safer when they discuss sexual feelings. If you ever have any questions about this professional ethic, please talk to your therapist or request the information booklet entitled "Professional Therapy Never Includes Sex." A related issue is hugging or holding. Some therapists are comfortable with these practices, and some are not. To prevent any misunderstandings, other than a handshake, any physical contact between you and your therapist should be discussed openly and agreed upon.

Use of Alcohol or Drugs During Sessions: You are asked to refrain from using alcohol and/or non-prescription drugs prior to your scheduled psychotherapy sessions. One aspect of therapy is to evaluate your emotional functioning on a regular basis. If you alter your emotional state with intoxicants, your therapist may misinterpret your abilities and needs and your therapy may be less effective.

Termination of Treatment: Termination of therapy occurs when the goals of treatment have been achieved or when either you or your therapist believes it is in your best interest. Termination may be a valuable part of your therapy experience and should not be taken lightly. We ask that you meet for at least one session after making the decision to terminate.

Right to Refuse Treatment: You have the right to choose not to receive therapy at Hill Country Community Clinic at any time. If you choose this, we will provide you with names of other qualified professionals whose services you might prefer. You also have the right to ask any questions and/or refuse any requests, suggestions, or techniques used during therapy.

My signature below indicates that I have read this statement, or had it read to me, and consent to treatment by Behavioral Health Services staff at Hill Country Community Clinic

Signature

Date

For Minors, Signature of Parent /Guardian (please state relationship)

Date

Witness: _____

HILL COUNTRY COMMUNITY CLINIC
Behavioral Health Services

CONFIDENTIALITY AND PRIVACY

Other than where stated below, the information you share with your therapist or any staff at the Hill Country Community Clinic is completely confidential, and will not be shared with anyone without your written permission (or your parents' permission if you are under 18 years old). Even when you have signed a Release of Information form our staff will always act so as to protect your privacy by providing only the minimum amount of information required. You may authorize your therapist to share information with whomever you choose, and you can change your mind and revoke that permission at any time.

LIMITATIONS ON CONFIDENTIALITY: There are exceptions to the confidential rights discussed above. Disclosure may be authorized or required by law in the following circumstances:

- If your therapist hears about or suspects child abuse or elder abuse, he/she is required to report this to the appropriate authorities.
- If your therapist learns from you or a family member that you intend to hurt or kill someone, and there is good reason to believe that you will follow through, he/she must attempt to warn that person and contact the police.
- If your therapist learns that you intend to kill yourself and you are unwilling to take steps to guarantee your safety, he/she and/or other staff must take steps to keep you safe, including calling the police or the county crisis team.
- According to the Health Care Information Act of 1992, during an emergency situation your therapist may legally speak to another health care provider or a member of your family about you.
- If you request the information directly, or if the court rules that subpoenaed information is not privileged.

COUPLES/FAMILIES: In couples or family therapy, please be aware that any information shared with your therapist will be disclosed to your partner or family if they are participating in treatment with you. Your therapist will not agree to hold secrets on any one person's behalf. If you feel something should not be shared with your partner/family, please do not share that information with your therapist. In these instances, it may be most appropriate for you to seek the support of an individual therapist who is independent of your couple's/family's treatment.

GROUPS: If you participate in group therapy at Hill Country Community Clinic you are expected to maintain complete confidentiality regarding information divulged by other group members.

CHILDREN AND ADOLESCENTS: Legally and ethically, a minor is generally entitled to a confidential relationship with a therapist. However, parent(s)/guardian(s) do have the right to waive this privilege, except in special circumstances, such as when the minor is a victim of a crime or when the therapist is seeing the minor without parental consent. Therapists can treat minors, age 12 or older, without parental permission when the minor would be a danger to self or others without treatment or is a victim of child abuse. At Hill Country Community Clinic, direct parental involvement in a child's treatment is preferable, either through conjoint sessions with the therapist and child, or separate sessions. If this is not appropriate in a particular case, parents may be given reports on their child's progress, but specific confidential information may be limited or not be revealed as this can compromise the therapeutic relationship. Parents have the legal right to access records about a child's treatment. This is true even for noncustodial parents. At the same time, in a situation where the parent's access would have a detrimental effect on the therapeutic relationship or the minor's physical or psychological well-being, the therapist is legally permitted to deny parental access to records.

CONSULTATIONS: Within Hill Country Community Clinic, your therapist is a part of a treatment team that includes medical and dental providers as well as other clinic staff. If your therapist believes it will be helpful, s/he may consult with other team members to ensure that you receive the best care possible.