Round Mountain Location
29632 HWY 299 East,
Round Mountain, CA 96084
P: (530) 337-5750 F: (530) 337-6655

Redding Location
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Redding, CA 96003
P: (530) 241-4100 F: (530) 241-4117

PATIENT REGISTRATION

Patient Information (Please print clearly) Name must match what is on your insurance card(s) or we may not be able to bill.

Last Name: _____ **First:** _____ **M:** _____

Birthdate: _____ **Sex**: ❑F ❑M **SSN#** _____ **Marital Status:** ❑S ❑M ❑D ❑W ❑SEP

Mailing Address: _____ City**:** _____ ST:_____ Zip:_____

Physical Address (if different)**:** _____ City:_____ ST:_____ Zip:_____

Home Phone: _____ **Work:** _____ **Cell**: _____

Message#: _____ **Email Address**: _____

Preferred Method of Contact: ❑Home Phone ❑Work ❑Cell ❑Message Phone ❑Text **Okay to Leave Message?:** ❑Yes ❑No

Emergency Contact: _____ **Phone:** _____

Relationship: _____ **Does this person know that you are a patient at Hill Country?** ❑Yes ❑No

Parent or Guardian (if patient is minor)

Parent/Guardian Name: _____ Relationship to Minor: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Guardian Name: _____ Relationship to Minor: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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 (Check all that apply)**:** ❑White ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑Asian ❑Chinese ❑American Indian/Alaskan Native ❑Filipino ❑Japanese ❑Korean ❑Other ❑Declined

Ethnicity: ❑Hispanic/Latino ❑Non-Hispanic/Latino ❑Declined

Sexual Orientation: ❑ Lesbian or Gay ❑Straight ❑Bisexual ❑Something Else ❑Choose not to disclose

Gender Identity: ❑ Male ❑Female ❑Transgender Male/ Female-to-Male ❑Transgender Female/ Male-to-Female ❑Other ❑Choose not to disclose

Are you a Veteran?: ❑Yes ❑No **Agricultural (Farm) Worker?:** ❑Yes ❑No **If yes, are you:** ❑Seasonal ❑Migrant

Homeless: ❑Yes ❑No **If yes, currently living in:** ❑Shelter ❑Transitional Housing ❑Doubled Up ❑Street ❑Other

Family Size: _____ **What is your Average Monthly Income:** _____ **❑Declined to provide information**

SIGNATURE: _____ **DATE:** _____
The preceding information is true to the best of my knowledge.

Chart #_____

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Patient Consents

Consent for Medical/Dental Treatment

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

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.

If 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:_____

Relationship to patient:_____

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 Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Chart #_____

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Patient Financial Agreement

Medical & Dental Insurance Policies

Primary MEDICAL Insurance Name: _____

Policy ID#_____ Group #_____ Effective Date: _____

Guarantor Name:_____ Relationship to patient:_____

Date of Birth:_____ SSN#:_____ Sex: ☐F ☐M

Address: _____ Phone:_____

Secondary MEDICAL Insurance Name: _____

Policy ID#_____ Group #_____ Effective Date: _____

Guarantor Name:_____ Relationship to patient:_____

Date of Birth:_____ SSN#:_____ Sex: ☐F ☐M

Address: _____ Phone:_____

DENTAL Insurance Name:_____

Policy ID#_____ Group #_____ Effective Date: _____

Guarantor Name:_____ Relationship to patient:_____

Date of Birth:_____ SSN#:_____ Sex: ☐F ☐M

Address: _____ Phone:_____

PLEASE PROVIDE YOUR PRESCRIPTION COVERAGE CARD IF DIFFERENT FROM ABOVE

Medicare Beneficiary Screening: Please answer the following questions ONLY if you have Medicare Insurance

As a direct result of mandated Medicare Secondary Payer (MSP) Regulations, HCCC is required to gather information to determine if Medicare is your primary insurance.

1. Is this visit due to an automobile accident, liability accident or Workman's Compensation? ☐Yes ☐No

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2. Is this visit covered by the Black Lung Program, Veterans Administration program or a government research program? ☐Yes ☐No

3. Under 65 and an end stage renal patient in your first 36 months of Medicare entitlement? ☐Yes ☐No

4. If under age 65, is your Medicare coverage due to disability? ☐Yes ☐No

5. Are you covered by a health plan through your employer or spouse's employer? ☐Yes ☐No

Office use only:
A. If patient responds "no" to questions 1-5, Medicare is primary.
B. If patient responds "yes" to any questions 1-5 and there is a second insurance (other than "Medicare Supplemental plan, Part D or Medi-Cal), Medicare is secondary and primary insurance information must be obtained.

Payment and Billing Policy

- **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 qualifying patients who are unable to afford care

- 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.

I have read the above Patient Financial Agreement and agree by signing below.

Patient Name:_____

Responsible Party: _____

_____

Signature of Responsible Party **Date**

Chart #_____

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HILL COUNTRY HEALTH AND WELLNESS CENTER SHARED HEALTH INFORMATION PROTECTION POLICY & INFORMED CONSENT

Hill Country's Electronic Health Record system enables our team of health care providers and staff to efficiently share patient information with each other, which means better communication between all of your providers and more comprehensive care for you. Our goal is to provide you the best possible care, which means that your medical, dental and behavioral health providers will all have access to certain information about your health and treatment.

Hill Country also shares your health information using the regional Health Information Exchange, SacValley MedShare. This important feature allows your doctors at other locations (such as hospitals and emergency rooms) to quickly access to your health records even when our offices are closed. Hill Country and SacValley MedShare use the highest standards to ensure the safety and privacy of your records in this process. For more information about SacValley MedShare see their website at http://sacvalleyms.org/

The items that may be shared with your Hill Country healthcare teams and SacValley MedShare are identified in the following table:

Hill Country Providers Only	**SacValley MedShare (HIE)**
Physical and Mental health conditions, history, including symptoms and diagnoses, prognoses	Allergies, Adverse Reactions
Treatment goals and plan, including medications and other recommendations	Problems list
Results of test or other evaluations used to diagnose or develop interventions	Medications list
Specific concerns about your health, safety or emergency needs	Vitals Signs
Follow up plan, including referrals for other care types or specialties	Encounter codes and procedure codes
Updates regarding your health status, functioning, participation and progress	Lab Results

IMPORTANT NOTE ABOUT BEHAVIORAL HEALTH INFORMATION: Other than the information listed above, the specific contents and analysis of conversations between you and your therapist during a psychotherapy session is not shared. This information has special protection under the law and a separate consent form must be signed by you before such information can be shared.

Continued on other side

Chart #_____

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Please read the following options carefully and check the appropriate box:

☐ **I authorize Hill Country Health and Wellness Center to share my health information (medical, dental and behavioral health) with my providers at Hill Country AND SacValley MedShare as stated above.**

☐ **I authorize Hill Country Health and Wellness Center to share my health information (medical, dental and behavioral health) with my providers at Hill Country. I do not allow my records to be shared using SacValley MedShare. Opt Out Form provided_____**

_____ _____
Signature Witness (if required) Date

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

Chart #_____

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PATIENT HEALTH HISTORY

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

Allergies: _____

_____

Current Medication List: _____

_____

_____

_____

Past or Current Medical History – Check all that apply

□ Allergies_____
□ Anxiety_____
□ Arthritis_____
□ Arthritis, Rheumatoid_____
□ Asthma _____
□ Atrial Fibrillation_____
□ Anemia_____
□ Bleeding Disorders_____
□ Bladder Problems_____
□ Coronary Artery Disease_____
□ Chronic Obstructive Pulmonary Disease (COPD)

_____
□ Cancer_____
□ Congestive Heart Failure (CHF)_____
□ Diabetes_____
□ Depression_____
□ Eyesight Problems_____
□ Gallbladder Disease_____
□ Gastric Ulcer_____
□ GERD_____

□ Gout_____
□ Hearing Loss_____
□ Hepatitis_____
□ HIV Infection_____
□ Hyperlipidemia (High Cholesterol)_____
□ Hypertension (High Blood Pressure)_____
□ Hypothyroidism_____
□ Aortic Aneurysm_____
□ Insomnia_____
□ Low Back Pain_____
□ Migraine Headaches_____
□ Obesity_____
□ Osteoarthritis_____
□ Osteoporosis_____
□ Peripheral Vascular Disease_____
□ Psychiatric Disorders_____
□ Seizure Disorders_____
□ Sleep Apnea_____
□ Venereal Diseases_____
□ Pregnancies #_____ □ Children # _____

Chart #_____

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Surgical History

Eye Ear Nose Throat

□ Cataract_____

□ Thyroid Surgery_____

□ Tonsillectomy_____

□ Adenoidectomy_____

□ Ear Surgery_____

Cardiovascular Surgery

□ Aortic Aneurysm_____

□ Angioplasty_____

□ CABG_____

□ Heart Valve_____

□ Cardiac Stent_____

□ Vascular Surgery_____

Breast Surgery

□ Mastectomy_____

□ Lumpectomy_____

□ Augmentation _____

Gastrointestinal Surgery

□ Abdominal Surgery_____

□ Appendectomy_____

□ Cholecystectomy (gallbladder removal)_____

□ Gastric Surgery_____

□ Hernia Repair_____

□ Ulcer Surgery_____

□ Laparoscopy_____

□ Pancreatic Surgery_____

□ Skin Surgery_____

Orthopedic Surgery

□ Joint Surgery_____

□ Carpal Tunnel_____

□ Back Surgery_____

□ Other_____

_____

GYN/GU Surgeries

□ Cesarean (C-section)_____

□ Hysterectomy_____

□ Tubal Ligation_____

□ Vasectomy_____

□ Bladder Surgery_____

□ Prostate Surgery_____

□ Kidney Surgery _____

Other Disorders or Diagnosis that you have been given by any doctor _____

_____

ER or Urgent Care (Recent): _____

_____

Previous Hospitalizations: _____

(Please list details, such as, _____

reason, year, facility, etc) _____

Social History: Alcohol: Type _____ How much/often?_____

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Caffeine: Type_____How much/often?_____

Tobacco: Type _____ How much/often?_____

Street Drugs: Type _____How often?_____

Exercise: Type_____How much/often?_____

Special Dietary Needs:_____

Work History: Type of Work_____ Full Time, Part Time, Retired, Disabled
(Circle one of the above)

Family History: Mother: Age:_____ *Living or Deceased*

If deceased, cause of death: _____

Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Father: Age:_____ *Living or Deceased*

If deceased, cause of death: _____

Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Brother(s): Age:_____ *Living or Deceased*

If deceased, cause of death: _____

Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Sister(s): Age:_____ *Living or Deceased*

If deceased, cause of death: _____

Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Other Pertinent Family History: _____

_____

_____

List Routine Care by Other Doctors/Specialists/Hospitals:

_____

_____

Recent Health Maintenance:

□	Pap Smear:	Year _____	Results_____
□	Mammogram	Year _____	Results_____
□	Colonoscopy	Year _____	Results_____
□	Cholesterol Screen	Year _____	Results_____
□	Pneumonia Shot	Year _____	
□	Tetanus: Tdap, Td	Year _____	

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Additional Medical Health History Information:

Chart #_____

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Conflict of Interest Disclosure

If there is anyone at Hill Country Community Clinic that you do not want to have access to your medical, dental, or behavioral health records, please list their names and the reason why:

1. _____
   _____
2. _____
   _____

A representative from our office may contact you for more information. All information disclosed is kept confidential and used only to keep your personal information secure.

Patient Consent for the Release of Information On Voicemail or Answering Machine

I, _____ , give my permission for the following normal information (Lab results, Pap test results, Pathology reports, X-ray results) and Referrals, Prescriptions, and Appointment information to be left on the voicemail/answering machine of my choice.

I understand I also have the option to review or request some of this information via the Patient Portal.

Please select all that apply:

- ☐ Home Phone: _____
- ☐ Work Phone: _____
- ☐ Cell Phone: _____
- ☐ Other: _____

This authorization is effective until rescinded by myself in writing.

_____
Patient Signature Date

_____
Witness Signature Date

Chart #_____

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Patient Consent to Obtain Medication History

As a user of an electronic medical record, your Hill Country provider would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

An accurate medication history is **very important** to help us treat you and to avoid potentially dangerous drug interactions.

Your medication history might not include over the counter medicines, supplements or herbal remedies. **It is still very important for us to take the time to discuss everything you are taking,** and for you to tell us about any errors in your medication history.

Please initial your choice and sign below.

_____ **I give permission** for Hill Country Health and Wellness Center to obtain my medication history from my pharmacy, my health insurance (including state and federal benefits programs) and my other healthcare providers or drug and alcohol treatment programs.

OR

_____**I DO NOT give permission for** Hill Country Health and Wellness Center to obtain my medication history from my pharmacy, my health insurance nor my other healthcare providers.

By signing this consent form you give us permission to collect, and give your pharmacy and your health insurance permission to give us information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

_____ _____

Print Patient Name Patient's Date of Birth

_____ _____

Signature of Patient or Guardian/Parent Date

_____ _____

Relationship to Patient

Chart #_____

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other (*Specify*)		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Hill Country Health & Wellness Center Sliding Fee 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	Household Family Members (include self)	Relationship	Date of Birth	Age	Gross Monthly Income	Name of Current Insurance Plan

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: **OVER INCOME/DENIED:** ☐ **PT REFUSED APPLICATION:** ☐ **CATEGORY:** **A** **B** **C** **D** **E**

TOTAL HOUSEHOLD INCOME:_____ **FAMILY SIZE:**_____ **SF% DISCOUNT** _____

REVIEWED BY(Initial):_____ **DATE REVIEWED:**_____ **EFFECTIVE DATE:**_____ **RENEW 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:

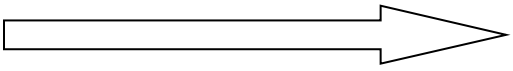
1. You must complete the Financial Information/Program Application form annually to determine your eligibility and discount. This information includes:
    a. Your total household income from all income sources before taxes
    b. Number of family members living in your household
2. At our discretion, 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 

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