Office Use Only:

Provider: ____________________

Amount per visit: _____________

Athena ID: ___________________

ER: Y / N INS: Y / N

Old Chart: ____________________

PATIENT INFORMATION

Date : ___________________________

First Name
Nombre _________________________

Last Name
Appelido_________________________

Middle Initial
Initial _______________

Sex
Raza____________

Date of Birth
Fecha de Nacimiento______________________

SS#
Seguro Soc ___________________________

Address
Domicilio____

APT #______________________________

City
Ciudad ______________________

State
Estado___________

Zip
Codigo ________________

County
Condado ________________

Phone numbers
Telephono______________________________

Home
____

Cell
____

Work
____

Race
Origin_______________________

DL or ID#
#De Liciencia ______________________

Marital Status
____

Employed Yes / No
Empleado posicion_____________________

Education MS HS College
Educacion ___________________

Occupation
Ocupacion___________________

Total Monthly Income of Entire Household
Entrad de Dinero Mensualdo Todas las Personas en Casa $_______________________________________

Total Number of Persons in Household
Total las Personas en Casa ___________

Number of children under 18
Numero de Ninos Abajo de 18 __________

Release of Information to Family/Friend

Our practice may release your personal health information to anyone of your choosing. If there is someone you would like us to be able to release health information to, please list their name and sign and date below.

Name:	**Relationship to you:**
____	____
____	____
____	____

Patient Signature: ____ **Date**: ______________________

Revised April 2018

PRESBYTERIAN MEDICAL CARE MISSION

General Consent to Treat

I have the legal right to consent to medical treatment because (a) I am the patient or (b) I am the guardian of the patient.

All references to "patient", "me" and "my" in this document means: ______________________________**(name of patient).**

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Presbyterian Medical Care Mission and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, family nurse practitioners, physician assistants, nurses, and other health care providers in the medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.
_________(Please initial)

Sharing Records for Treatment

We share medical records electronically with other healthcare providers to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical system, they may have access to your medical record.
_________ (Please initial)

Voicemail Messaging

As a service to our patients, Presbyterian Medical Care Mission provides courtesy appointment reminder calls and possible other important calls that may be placed using a prerecorded auto messaging system. The information may include protected health information. By initialing below, you consent to receiving such calls at the phone number you have provided to us.
__________(Please initial)

Electronic Prescriptions (E-Prescribing)/Medication History

I voluntarily authorize Presbyterian Medical Care Mission to allow E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as a physician/patient relationship exits, or until I withdraw my consent. This includes prescription medication to treat AIDS/HIV, Hepatitis C, and medicines used to treat mental health issues such as depression. I give permission for my healthcare provider to obtain my medical or medication history from my pharmacy, health plans, hospital, or other healthcare providers.
__________(Please initial)

Acknowledgment: Notice of Privacy Practices

I acknowledge receiving Notice of Privacy Practices ("Notice"). The Notice explains how Presbyterian Medical Care mission may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records.
___________(Please initial)

I have read this form and I have had an opportunity to ask questions about it.
__________(Please initial)

Patient's name (Print)____Date of Birth___________________________

Signature of Patient or Patient's Representative: ____Date ________________

CANCELING APPOINTMENTS

Please contact us if you need to cancel or re-schedule your appointment. If you fail to do so, this will be considered a NO SHOW. ***THREE (3) NO SHOWS and you will be dismissed as a patient at the Mission.***
(Por favor de llamar a la clinica si necesita cancelar su cita. Si no llama a cancelar su cita se considera que FALTO A SU CITA. Si usted falta A TRES CITAS sera despedido de la clinica y ya no podra ser atendido como paciente.)

SIGNATURE______________________________________ **DATE** __________________________
(FIRMA) **(FECHA)**

EQUAL OPPPORTUNITY

Standards for participation in the clinic program are the same for everyone, regardless of sex, race, creed, national origin, or political beliefs.
(Las normas de participacion en el programa de la clinica son las mismas para todos a pesar del sexo, raza, creencias, nacioinalidad, o inclinacion politica.)

PRESBYTERIAN MEDICAL CARE MISSION
Uninsured Patient Statement

I certify by signing this document, I do not have **Medicaid, Medicare, private health insurance, or VA Health Benefits,** and my appointment is ***not*** for a **worker's comp insurance claim** or **motor vehicle accident.**

Patient Name (Print):____

Patient Signature: ____

Date: ____

Revised April 2018

PRESBYTERIAN MEDICAL CARE MISSION—RIGHTS AND RESPONSIBILITIES

Welcome as a patient to PMCM (Presbyterian Medical Care Mission). Our mission is to provide you with quality healthcare, with care and compassion. In order to fulfill our mission, the following rights and responsibilities have been established to assure our purpose can be met:

You have the right:

- To be treated with the utmost respect and dignity no matter your ethnicity, gender, religion or income.
- To health care and treatment that is reasonable for your condition and within our scope of services.
- To make decisions about your health care while discussing it with your provider.
- To refuse treatment, care and services allowed by the law while understanding the risks that could occur with this refusal.
- To personal privacy and confidentiality during interview, examinations, and treatment. Please review the "Notice of Privacy Rights" for more information.
- To access your medical records.
- To speak to someone on the management team if you have a concern.

You are responsible:

- To treat the PMCM staff with the respect and dignity allowed to them. The Executive Director of the PMCM has the right to refuse service to anyone acting in an inappropriate manner.
- To comply with medical recommendations.
- To provide PMCM with accurate information about your financial status and resources as well as any changes that may occur. This includes notification if you obtain Medicaid, Medicare, or other health insurance in a timely manner.
- To give payment for any diagnostic testing at the time of the scheduled service. We accept cash or check.
- To provide valid Social Security numbers on your patient information.
- To respect the privacy of other patients while in the clinic, please keep cell phones off and your family and visitors coming with you to a minimum.
- To supervise your children at all times. Unattended minors are not allowed in the waiting room. You are responsible for their safety and protection while visiting the clinic.

Patient Signature: ____ Date: ___________________________

Revised April 2018

PRESBYTERIAN MEDICAL CARE MISSION—NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") requires all medical records and other individually identifiable protected health information (PHI) used or disclosed by us in any form, whether electronically, on paper, or orally, to be kept confidential. You have rights to understand and control how your health information is used. We are required to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to PHI.

- Treatment: providing, coordinating, or managing health care and related services by one or more health care providers. We may disclose your information to doctors, nurses and other healthcare personnel who are involved in your care.
- Health Care Operations: for appointment and patient recall reminders. Also includes the business aspects of running our practice, such as conducting clinic improvement activities, employee training, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.
- When required to do so by federal law: This may include the following: 1) business associates, 2) to avert a serious threat to health and safety, 3) public health risks, 4) health oversight activities, 5) judicial and administrative procedures, 6) specific government functions, 7) research and organ donation, 8) coroners and funeral directors, and 9) communications with caregivers and relatives.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the management team.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, and any other person identified by you.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means.
- The right to inspect and copy your protected health information. A $15 fee will be charged for paper copies of your health information. There is no charge to transfer your information electronically to another health facility. However, a written signed release is required.
- The right to amend your protected health information.
- The right to receive a list of how your protected health information was disclosed other than treatment, payment or health care operations, as listed above.

I have received a copy of the notice of Privacy Practices, or I have been offered a copy of the "Notice", and I understand that if I do not receive one now, I may request and receive one at a later time.

Patient Signature:______________________________Printed Name:______________________________Date:_________

You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint. If you have any questions or to make a request regarding the rights described above, please contact:

Presbyterian Medical Care Mission
Management Team
1857 Pine Street, Suite 100
Abilene, Texas 79601
325-676-3104

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775