ENGLISH

ENROLLMENT REQUIREMENTS FOR SLIDING FEE PATIENTS

1. **Proof of Household Income from everyone in the household who works family and non-relatives.**

- Most recent **paycheck stubs**, (***please bring at least 3-4 paycheck stubs) (Must be dated within 30 days of registration)*** *OR*
- **Previous year tax return**, *OR*
- **Employer statement of income**, which states gross income and frequency of pay. This letter must be **DATED, SIGNED** and include a **TELEPHONE NUMBER**. **(HHM HAS THE EMPLOYMENT FORM THAT MUST BE FILLED OUT BY THE EMPLOYER. WRITTEN/TYPED WILL NOT BE ACCEPTED. YOU CAN GET THIS FORM AT ANY OF OUR OFFICES.**

Award Letter received from **(GOVERNMENT ASSISTANCE)**
ONLY IF THIS APPLIES TO YOU OR ANYONE IN YOUR HOUSEHOLD:

- **Food Stamps**
- **Child Support**
- **Social Security/ Disability**
- **Unemployment**
- **SSI**
- **Public Housing**
- **TANF**

2. **Valid Picture ID** and **Insurance Card** if any

3. **Proof of Address: (Electricity bill, water bill, apartment lease or mortgage documents)**

4. **You will need to recertify every 12 months from when you last renewed or registered.**
   To recertify you will be required to bring in the updated documents mentioned above.

5. **HHM Slide Fee Card and a phot ID will be Required at every appointment.**

6. **There is a $10 fee that is collected for replacement HHM Slide Fee cards.**

All information provided must be current, dated within the last 30 days. Please make sure to bring all required documents at time of registration.

All registrations can be taken to Suite 360 on 5750 Pineland Dr.

Registration Hours:

Monday –Friday
8:00am- 4:00pm

The Enrollments may also be completed at any HHM Health Facility.

Patient Registration Form

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Home Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **SS#:** _____/_____/_____ **Home Phone** (___) _____ **Cell Phone (___)** _____

Work Phone (_____) _____ **Email:** _____

Emergency Contact: Name: _____ Phone: _____ Relation: _____

Marital Status:
☐ Married
☐ Single
☐ Widowed
☐ Divorced

Preferred Communication:
☐Home
☐Work
☐Cell
☐Email

May we leave a voicemail regarding medical results
☐Yes
☐No

Gender Identity:
☐ Male
☐ Female
☐ Transgender Man
☐ Transgender Woman
☐ Other
☐ Choose Not to Disclose

Sexual Orientation
☐Straight/Heterosexual
☐Lesbian or Gay/Homosexual
☐Bisexual
☐Other
☐Choose Not to Disclose

Primary Language:
☐English
☐Spanish
☐Signing/ASL
☐Other: _____

Preferred Pharmacy:
☐HHM Health
☐Other: _____

Ethnicity:
☐ Mexican/Mexican American/Chicano
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic/Latino/Spanish Origin
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Decline to Specify

Race:
☐Caucasian/White
☐African American/Black
☐American Indian/Alaska Native
☐Asian Indian
☐Chinese
☐More than One Race
☐Filipino
☐Japanese
☐Korean
☐Vietnamese
☐Other Asian
☐Decline to Specify
☐Native Hawaiian
☐Samoan
☐Guamanian/Chamorro
☐Other Pacific Islander
☐More than one race
☐Other: _____

Are you a Verteran:
☐ Yes
☐ No

Are you Homeless:
☐Yes
☐No

If yes, check all that apply:
☐Doubling Up
☐Shelter
☐ Street
☐Transitional
☐Unknown
☐Other

Are you in need of housing assistance?
☐Yes
☐No

Are you an Agricultural Farm Worker?
☐ Seasonal Worker
☐ Agricultural Worker
☐ Dependent of Ag Worker
☐Dependent of Seasonal Ag Worker
☐Not an Agricultural Worker

Parent/Legal Guardian Information – Please complete if patient is under 18 years of Age

Mother's Name: _____ **DOB:** _____ **Phone:** _____

Father's Name: _____ **DOB:** _____ **Phone:** _____

Legal Guardian's Name: _____ **DOB:** _____ **Phone:** _____

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Insurance Information

***Co-payments are required at time of visits and/or payment for services not covered by insurance.**

Insurance Type:
☐ Private Insurance
☐ Self-Pay
☐ Medicaid
☐ Medicare
☐ Other

Plan Name:
Primary Insurance: _____ Policy/Member ID Number: _____

Plan Name:
Other Insurance: _____ Policy/Member ID Number: _____ Group Number: _____

Guarantor Information (Person financially responsible for any patient balance): ☐Check if same as patient

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number (optional): _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Subscriber Information (person who carries the insurance): ☐Check if same as patient

Name: _____ Date of Birth: _____

Relations to Patient: _____ Social Security Number (optional): _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Dental Insurance Information:

Insurance Name: _____ Policy/Member ID: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____ Relation: _____

Patient Income Information

All information is strictly confidential

HHM Health is a Federally Qualified Health Center (FQHC) and can offer discounted services to patients based upon financial ability or inability to pay. This program requires us to obtain income and household information from each patient for whom we provide services. If you qualify, you will pay a discounted amount for your care at HHM Health.

If you wish to be considered for the Sliding Fee Scale, please complete the following section of this form in its entirety. Failure to submit all the required information will delay in the determination of discounted services. (note: some sections may be repeated in comparison to the Patient Registration Form, please continue to complete the form entirely)

If you do not wish to be considered for the Sliding Fee Scale, please acknowledge by checking the box below and providing your signature. Patients declining to be considered for the Sliding Fee Scale do not need to submit income and household information. In addition, you may skip the remainder of the Patient Income Information form.

☐ I do **not** wish to be considered for a Sliding Fee Scale, and I understand services will be priced using customary fees.

_____ _____

Patient or Parent/Guardian Signature (if patient is under 18 yrs old) **Date**

Section I: HEAD OF HOUSEHOLD (please print in all section of document)			
Last Name:	First Name:	Middle Initial:	# of Dependents:
Street Address:	City:	Zip:	County:
Date of Birth:	Social Security Number:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed	

Section II: INCOME (please complete for each adult household member who is employed or has any source of income)			
Employed Person	**Company Name**	**Gross Income (before taxes)**	**Paid How Often (check one)**

Other Sources of Income			
Child Support $	Alimony $	Unemployment $	Disability $
Pension/Retirement $	TANF $	Social Security $	Other $

Health insurance coverage: ☐Medicaid ☐Chip ☐Medicare ☐Private Insurance ☐None

SECTION III: MEMBERS OF THE HOUSEHOLD (list all individuals in the household, including the Head of Household first)

Name (First, Middle, Last)	Date of Birth	Age	Name (First, Middle, Last)	Date of Birth	Age
1.			5.		
2.			6.		
3.			7.		
4.			8.		

By signing below, I agree that the HHM Health staff may contact each employer listed and/or other agencies to confirm my income. I will provide HHM Health with proof of income for the purpose of calculating my discount, if I qualify. I will be asked to document my income regularly (annually if tax return is provided/monthly if paystubs or insurance is provided), and I agree to inform HHM Health if there are any changes to income, household size, or insurance coverage indicated above. I understand that certain services and/or items cannot be discounted. I agree to pay my co-pay at the time of services. I hereby certify that the information I have provided is complete and correct to the best of my ability.

_____ _____

Patient or Parent/Guardian Signature (if patient is under 18 yrs old **Date**

HHM Health Partnership in Care Agreement

HHM Health is pleased to be a partner with you in your healthcare. We know that managing your health includes you being involved. You, as a patient, are in control of your health. The choices that you make every day have an impact on your health. Your diet, exercise, and other decisions you make impact your health as much as or more than any physician.

We are committed to educating you about your health and working with you. Having better information and taking an active role can help you make healthier decisions. We encourage you to ask questions and share ideas with our healthcare team.

We will encourage you to take an active role in your healthcare by making the following wise choices for each visit that you have:

1. Always bring all medications that you are taking with you to each visit. (Prescription drugs, over-the-counter medicines, vitamins, and herbal remedies and supplements)
2. Make a list in advance of things that you may want to discuss at your appointment.
3. Be sure to make transportation plans in advance and arrive 20 minutes early to each appointment.
4. Be sure to ask questions if you don't understand something.
5. Follow the plan of treatment recommended by your physician.
6. Take all medications as directed.
7. Respond to all communications from the clinic.
8. Please review the clinic rules, be compliant, and keep a copy of them with your records.
9. Inform of any address, telephone number(s), and income or insurance changes.
10. **24 hours in advance notice if unable to keep appointment. Failure to keep the appointment or give notice 24 hours in advance will result in a $10 no-show fee that will be billed.**
11. Arriving late for an appointment will result in being rescheduled for the next available time.
12. **Patients that fail to keep or cancel their appointments three times in a 12-month period or five times for Children under the age 18 may be prevented from scheduling future appointments for a period of six months and will be seen on a same-day or walk-in basis only.**
13. I understand my treatment may be unsuccessful if I fail to follow the physician's orders and referrals.
14. There is no cell phone usage or any charging of cell phones in the clinic.
15. HHM Health reserves the right to refuse services to patients that have conducted themselves in a manner that is considered inappropriate. (Uncooperative, verbally abusive, intoxicated, etc.)

Patient: _____ _____
Signature **Date**

Patient Name: _____
Printed Name

Employee Witness: _____ _____
Signature **Date**

MRN #: _____

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HIPAA Authorization Release Form

Notice of Privacy Practices Acknowledgement

_____(Patient initials) I acknowledge that I have received HHM Health Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the HHM Health Notice of Privacy Practices.

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, _____, an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

> All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

1. Name: _____ Relationship: _____ Phone No.: _____

2. Name: _____ Relationship: _____ Phone No.: _____

3. Name: _____ Relationship: _____ Phone No.: _____

□ **Information is not to be released to anyone.**

Complete the following by indicating those items that you want you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All health information**

☐ History/Physical Exam ☐ Past/Present Medications ☐ Lab Results ☐ Physician's orders
☐ Patient Allergies ☐ Operation Reports ☐ Consultation Reports
☐ Progress Notes ☐ Discharge Summary ☐ Diagnostic Test Reports
☐ EKG/Cardiology Reports ☐ Pathology Reports ☐ Billing Information ☐ Radiology Reports & Images
☐ Mental Health Records (excluding psychotherapy notes) ☐ Genetic Information (including Genetic Test Results)
☐ Drug, Alcohol, or Substance Abuse Records ☐ HIV/AIDS Test Results/Treatment
☐ Other _____

DELEGATION OF CONSENT – Please complete if patient is under 18 years of Age

I, _____, _____ as parent/legal guardian
PRINTED NAME RELATIONSHIP TO CHILD

give my permission to the following persons listed below to bring the above named child to HHM Health for treatment and to consent to all immunizations, injections, or other medical therapies and procedures as they seem appropriate.

1. Name: _____ DOB: _____ Relationship to Child: _____

2. Name: _____ DOB: _____ Relationship to Child: _____

3. Name: _____ DOB: _____ Relationship to Child: _____

Signature: _____ **Date:** _____
Signature of Individual or Individual's Legally Authorized Representative

Treatment and Payment Authorization

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

Name of person giving consent if different from Patient:

[Print Name]: _____

Relationship to Patient: □ Self □ Parent □ Guardian □ Other: _____

I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services to me at the center's service locations. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent, or until the center changes its services and asks me to complete a new consent form.

I understand that payment for medical service is due on the day of the visit. Payment may be made by cash or credit card. Insurance/Financial arrangements should be made with the center prior to any service.

Sliding Fee Discount Schedule

It is the policy of HHM to establish a sliding fee discount schedule based on a patient's ability to pay for all services within HHM's approved scope of project regardless of the mode of delivery i.e., Column I, II, or III of Form 5 for which there is an established charge. The SFDS is established and implemented to ensure that uniform and reasonable fees and discounts are consistently and appropriately applied to all HHM patients to address financial barriers to care. Eligibility for the SFDS will be based on income and family size and no other factors.

The components of the sliding fee discount schedule are as follows:

a. Definition of Income and Family Size
b. Documents required to be provided by patients to support definition of income.
c. Determination of eligibility guidelines
d. Structure of the Sliding Fee Discount Scale

Patient Responsibility Form

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that mid-level providers (Physician Assistants, Family Nurse Practitioners and Trained Medical Assistants) may be involved in my treatment, and I consent thereto.
4. I understand that I may be asked to sign a separate informed consent form for certain Treatment(s).
5. I hereby voluntarily give my consent to Treatment to the Center.
6. I the undersigned authorize the center to release any information acquired in the course of my treatment to my insurance company (s), another physician or medical facility (s). I hereby agree that I am responsible for said fee (s). I authorize payment directly to and assign to the center, if any,

_____

Signature of Patient/Legal Representative **Date**

_____

Print Name **Relationship to Patient**

_____

Signature of Witness, if not patient **Print Name** **Date**

Interpreter/Translator to complete when applicable:

I have accurately and completely read/translated the foregoing document to:

_____

Insert the Patient's or Patient's Legal Representative's Name

In _____, the Patient's or Patient's Legal Representative's primary language. S/He understood all of the terms and conditions and acknowledged his/her agreement and consent thereto by signing the document in my presence.
Interpreted/Translated

_____

Signature of Interpreter/Translator

_____

Print Name of Interpreter/Translator: **Date**