PATIENT REGISTRATION

Lone ★ Star
Circle of Care

PATIENT

Last Name		First Name		Middle Name
Social Security Number		Age	Date of Birth	
Mailing Address			Apt No	
City	State		Zip	County

By providing the phone number(s) below, you agree that LSCC and companies working for LSCC may confidentially contact you and/or leave a message. Messages may include communications that are pre-recorded and automatically dialed, however these calls will never include advertisements or marketing. If you provide your email address or cell number, we will send you general updates and appointment reminders via email or text message. These updates will not include specific information about your treatment or diagnosis. These general updates and reminders will not be encrypted. You may unsubscribe at any time.

Home Phone	Work Phone	Cell Phone	Email Address

Birth Sex: ☐ Male ☐ Female

Current Gender: ☐ Male ☐ Female ☐ Undifferentiated

Gender Identity (This section is optional for patients under 18)
☐ Male ☐ Female ☐ Transgender male/female-to-male(FTM)/Trans Man
☐ Transgender female/Male-to-Female(MTF)/Trans Woman
☐ Genderqueer- neither male nor female ☐ other ☐ Choose not to answer

Sexual Orientation (Optional for patients under 18)
☐ Straight or Heterosexual
☐ Lesbian, Gay, or Homosexual
☐ Bisexual ☐ Something else
☐ Choose not to answer ☐ Don't know

Preferred contact method (Choose all that apply):
☐ Phone call
☐ Text
☐ Voice Reminders
☐ opt out

Race (may select more than one):
☐ American Indian or Alaska Native
☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander
☐ White ☐ Choose not to answer

Preferred Pronoun:
☐ He, him, his ☐ Other
☐ She, her, hers ☐ Ze, hir
☐ They, them, theirs
☐ Decline to answer

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Choose not to answer
☐ Other
☐ Unknown

Preferred Language:

Marital Status:
☐ Married
☐ Single
☐ Divorced/Separated
☐ Widowed

Are you a US Military Veteran? (does not include active duty military service)
☐ Yes ☐ No

Are You Homeless? ☐ Yes ☐ No

Migrant Farm Worker; If yes, choose one of the following:
☐ Seasonal ☐ Migrant

Primary Insurance Name	ID#	Group #	policy holder name
Secondary Insurance Name	ID#	Group #	policy holder name

Complete this section only if patient is a minor (not applicable for family planning services)

PARENTS

Parent / Guardian #1		Parent / Guardian #2	
Mailing Address ☐ Check if same as above		Mailing Address ☐ Check if same as above	
City/State/Zip		City/State/Zip	
Date of Birth	Home Phone	Date of Birth	Home Phone
Work Phone	Cell Phone	Work Phone	Cell Phone
Social Security Number	Employer	Social Security Number	Employer
Relationship to child: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ other ________________		Relationship to child: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ other ________________	

RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY

I hereby authorize Lone Star Circle of Care (LSCC) to release any medical or other information needed to process all insurance claims. I authorize payment of insurance benefits directly to LSCC. I agree that I am responsible for payments for services rendered, deductibles and coinsurance. I am aware that failure to pay may result in termination of the patient/clinic relationship. A photocopy of this authorization shall be considered as valid as the original. This authorization will remain in effect until revoked by me in writing.

By signing this form, I am saying that I understand what is written above and that I voluntarily ask for and consent to treatment.

Patient or Authorized Signature	*Date*

Patient Name: ________________________________ Date of Birth: ________________ Date: ____________

Household/Family Size and Annual Income:

Lone Star Circle of Care is a Federally Qualified Health Center (FQHC). To meet certain program requirements, we must gather the following information on all patients.

Instructions: Please find your household size on the left and then answer the questions on the right. A household means a person or a married couple and any children under the age of 19 living in the same home. Include any children that you are taking care of that are living in your home without their parents. Yearly income is defined as all money received, before taxes.

Total number in your Household including you. (please circle)	Only check the "Yes" or "No" box below for the row that corresponds to the number of people in your household.				Write annual income in only one box below.
1	Household annual income less than $24,980?	Yes ☐	No ☐	If yes, what is your household annual income?	$
2	Household annual income less than $33,820?	Yes ☐	No ☐	If yes, what is your household annual income?	$
3	Household annual income less than $42,660?	Yes ☐	No ☐	If yes, what is your household annual income?	$
4	Household annual income less than $51,500?	Yes ☐	No ☐	If yes, what is your household annual income?	$
5	Household annual income less than $60,340?	Yes ☐	No ☐	If yes, what is your household annual income?	$
6	Household annual income less than $69,180?	Yes ☐	No ☐	If yes, what is your household annual income?	$
7	Household annual income less than $78,020?	Yes ☐	No ☐	If yes, what is your household annual income?	$
8	Household annual income less than $86,860?	Yes ☐	No ☐	If yes, what is your household annual income?	$
9	Household annual income less than $95,700?	Yes ☐	No ☐	If yes, what is your household annual income?	$
10	Household annual income less than $104,540?	Yes ☐	No ☐	If yes, what is your household annual income?	$

Transportation:

Do you ever miss, reschedule, or cancel appointments due to transportation problems? (Please check one)

Yes ☐ No ☐

Where did you hear about Lone Star Circle of Care? (Please select one option below):

- ☐ Family or Friend
- ☐ Online Search
- ☐ Social Media (Facebook, etc.)
- ☐ 211
- ☐ Radio
- ☐ LSCC Outreach Worker
- ☐ Flyer
- ☐ School
- ☐ Health Fair
- ☐ Insurance Provider
- ☐ Other: ____________________________

Lone ★ Star
Circle of Care

Family, Friends, or other Emergency Contact Information

Please list the family members, friends, or other emergency contacts, if any, whom we may inform about general medical conditions and your diagnosis. Information regarding your medical condition and diagnosis will not be discussed with anyone other than the persons listed below. This form does not authorize the release of medical records to listed persons.

Name ______________________	**Name** ______________________
Relationship ______________________	**Relationship** ______________________
Phone Number______________________	**Phone Number**______________________

Acknowledgement of Review of Notice of Privacy Rights, Patient Rights & Responsibilities, and Speak Up for Infection Prevention

I have reviewed the Lone Star Circle of Care's **Notice of Privacy Practices**, which explains how my medical and psychological information will be used and disclosed, the **Notice of Patient Rights & Responsibilities**, which outlines my rights as a patient of Lone Star and defines my expected responsibilities as a LSCC patient, and the Joint Commission Handout **Speak Up**, which explains things I can do to prevent infection. I understand that I am entitled to receive a copy of all/any of these documents. I understand the information stated in the documents and was given an opportunity to ask questions.

Initial ________

Acknowledgement of Review of Appointment Policy

I have reviewed the Lone Star Circle of Care **Appointment Policy**. I understand that I am entitled to receive a copy of this policy. I understand the information stated in the policy, and the importance of keeping my appointments and showing up on time for appointments. ***I acknowledge that I agree to abide by this policy and have had an opportunity to ask any questions.***

Initial ________

Patient Name: ______________________________ **Date:** ______________

Signature of Patient or Personal Representative ______________________________

Name of Personal Representative, If Used ______________________________

Description of Personal Representative's Authority ______________________________

Lone ★ Star
Circle of Care

Statement of General Consent to Receive Services

Patient Name: ______________________________ **Date of Birth:** ____________

Lone Star Circle of Care (LSCC) provides services regardless of race, residence, religion, income, ability to pay for services, sex, age, national origin, color, sexual preference, or contraceptive preference.

I understand that medical and other health-related services at LSCC are provided by licensed and certified health professionals, including; physicians, resident physicians, nurse practitioners, physician assistants, midwives, social workers, nurses, dentists, dental assistants and hygienists, optometrists, and health educators. I also understand that, periodically, LSCC serves as a teaching site for nurses, physician assistant students, resident physicians and medical students, whose training is under the supervision of the clinic's professional staff, and that I have the right to refuse to be seen by a health professional trainee.

In the event that a staff member has a serious exposure to my blood or body fluids, I consent to the anonymous testing of any blood samples that I have already provided for evidence of a blood-borne virus infection. I also acknowledge that tests for certain communicable disease may be reportable to public health agencies as required by law. If necessary in the course of my care, I consent for my LSCC healthcare provider to access my medication history, if available, from retail pharmacies.

I understand that LSCC clinics provide ambulatory health care services and do not have the resources for emergency medical care. As an LSCC patient, I understand that I need to go to a hospital emergency room if I have a medical emergency. I understand that by signing below, I am consenting to medical services from LSCC and its providers, including but not limited to, physical exams, screenings and diagnostic tests, lab work, medication administration, and treatment. In the event my LSCC provider refers me to an outside healthcare provider for further diagnosis or treatment, I acknowledge that it is my responsibility to comply with any such referrals.

I understand that an initial routine screening for the Human Immunodeficiency Virus (HIV) may be performed on all patients ages 13-64, unless I exercise my right to decline this screening. Any questions I have about routine HIV screening may be discussed with my provider prior to the test.

I understand the information above and I voluntarily request and consent to the services of LSCC for myself or the individual for whom I am the parent or legal guardian. I understand that if I am under 18 years old and am unaccompanied by an authorized adult, there is an additional form I must complete to receive care at LSCC. I understand that I will have the opportunity to discuss with my LSCC provider the nature and purpose of recommended treatment or procedure(s), as well as alternative methods. I understand this consent is valid until revoked in writing, which I may do at any time.

______________________________ ______________________________

Signature of Patient Date

Signature of Consenting Adult Date
(Consenting Adult is parent or legal guardian)

______________________________ ______________________________

Printed Name of Patient

Printed Name of Consenting Adult

Patient Authorization for ICC

Integrated Care Collaboration (ICC) operates and manages a health information exchange (HIE) known as ICare. ICC participants include health care providers and entities such as doctors and hospitals. Your physician participates in the ICC. Payers of health claims such as Medicaid, Medicare, and private insurers also participate in the ICC. ICC's ICare system was created to help your doctor, and others who participate in your care, share your protected health information (PHI) in a secure way. We can only share your PHI through the ICC if you sign this Patient Authorization for ICC (Authorization).

This Authorization allows us to share your PHI only among ICC participants, each of whom has agreed to protect and secure your health information in accordance with state and federal law, including HIPAA's Privacy and Security rules. Except as explained below, to release your PHI *outside* of the ICC, you may need to sign a separate authorization at your hospital or doctor's office.

The kinds of PHI that may be shared through the ICC include:

- Diagnosis (disease or problem)
- Clinical treatment summaries & other documents in your medical record
- Results of lab tests, x-rays & other tests
- Medications (current and in the past)
- Personal information such as name, address, telephone number, social security number, gender, ethnicity & age
- Names of providers & dates of services
- Alcohol, drug abuse, mental & behavioral health treatment
- HIV/Acquired Immune Deficiency Syndrome (AIDS) test results & treatment
- Hepatitis B or C test results & treatment
- Domestic abuse information
- Reproductive health information, including testing & treatment for sexually transmitted diseases (STDs)
- Genetic test results & treatment
- Genome information, if provided
- Family medical history, if provided

By signing this Authorization, you agree that ICC, your health care provider, and other participants in ICC may use and disclose your PHI for the purposes of treatment, payment, and health care operations. ICC may also use your information in aggregated or de-identified forms for population health research and management or otherwise to improve the quality of care received by you and others in our community. For a list of current ICC participants, please go to: http://icc-centex.org/health-information-exchange/participating-organizations/.

By signing this Authorization, you also acknowledge that you understand that the ICare system is connected to other health information exchanges in Texas and across the country, including the national eHealth Exchange. If you need medical treatment outside of the ICC area, then these connections allow medical professionals to access your PHI. This Authorization allows your PHI to be shared in a new way, through a secured electronic network. It does not change who gets to review your PHI or the kinds of information shared.

You may change your mind and cancel this Authorization. To do so, you must send a cancellation notice directly to your provider or deliver or mail the cancellation notice or letter to:

Integrated Care Collaboration
8627 North Mopac, Suite 140
Austin TX 78759

If you cancel this Authorization, you understand it may take up to 72 hours (3 days) to lock your PHI in the ICare system. You further understand that the cancellation will not affect any actions that have already been taken in reliance on this Authorization.

Patient Name:____

Signature of Authorized Person:_____________________________________ Date: ____________________

Name (if different from Patient):______________________ Relationship to Patient: __________________________

Lone ★ Star
Circle of Care

LSCC Appointment Policy

We want to provide you with quality and timely health care. For this reason, we are open until 8 pm at some clinic sites and offer convenient hours on weekends. For us to offer these extended hours of service to all patients, it is important that you keep your scheduled appointments and arrive on time. We have reserved that time especially for you and we want to work together to meet your health care needs.

Your appointments are important to your health.

- Keep all of your scheduled medical, dental, vision, and behavioral health appointments.
- Keep and arrive on time for your scheduled program registration/financial screening appointments.
- If you know you cannot keep your schedule appointment, you must cancel it in a timely manner before the appointment so that we may offer it to someone else. Please call 877-800-5722 and give 24 hours' notice for behavioral health appointments, and 2 hours' notice for medical appointments.

What happens if you don't come to an appointment or don't cancel or reschedule it with the proper notice ("no-show")?

- You may be subject to limitations that prevent you from scheduling future appointments with specific providers or service lines.
- Before limiting access to appointments, LSCC will consider your individual circumstances, including whether you have children or other dependents who are patients of LSCC and the history of any cancellations or no-shows for those children or dependents. LSCC will also consider whether limiting access would greatly and negatively affect your health or the health of your family.

What happens if you are late?

- If you are late for your scheduled appointment time, you may experience a longer-than-usual wait time, as we may attempt to work you into the schedule for later that day or with a different provider.
- If we are unable to work you into the schedule for later that day or with another provider, or you decline these options, you may need to reschedule your appointment to another day.
- LSCC reserves the right to decide to reschedule your appointment if you arrive late for your scheduled appointment time.

We <u>want</u> to be your Health Care Home. Together, we can provide health care that revolves around <u>you</u>.

____ ______________________

Signature of Patient, Guardian, or Authorized Representative Date

Revised 04/19/2019