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 **$25,760**?	Yes ☐ No ☐	If Yes, What is your household annual income? $
2	Household Annual Income less than **$34,840**?	Yes ☐ No ☐	If Yes, What is your household annual income? $
3	Household Annual Income less than **$43,920**?	Yes ☐ No ☐	If Yes, What is your household annual income? $
4	Household Annual Income less than **$53,000**?	Yes ☐ No ☐	If Yes, What is your household annual income? $
5	Household Annual Income less than **$62,080**?	Yes ☐ No ☐	If Yes, What is your household annual income? $
6	Household Annual Income less than **$71,160**?	Yes ☐ No ☐	If Yes, What is your household annual income? $
7	Household Annual Income less than **$80,240**?	Yes ☐ No ☐	If Yes, What is your household annual income? $
8	Household Annual Income less than **$89,320**?	Yes ☐ No ☐	If Yes, What is your household annual income? $
9	Household Annual Income less than **$98,400**?	Yes ☐ No ☐	If Yes, What is your household annual income? $
10	Household Annual Income less than **$107,480**?	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: _____

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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 _____

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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: _____

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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

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Broad Consent to Participate in Future Research

IMPORTANT: If you have questions while reviewing this form, you can speak with a person who can go over it with you and talk about your concerns. Please ask us about anything in this form that you do not understand, and only agree if you have had all your questions answered and have had enough time to decide.

What are we asking you to do?

Many research studies ask patients to share health information about them for a single experiment or program. This form is different: we are asking you to share health information about you, including your identified health information (e.g., your name, your date of birth, your zip code), to be used in multiple different research studies in the future. **This is called a "broad consent for future research."**

Lone Star Circle of Care partners with academic and medical universities and institutions, including the University of Houston and the University of Texas, and other researchers, drug and device companies, and biotechnology companies to make it easier for researchers to study your information and improve the health of people like you.

What happens if you say yes?

If you say "yes" in this form, researchers in the future may use your identifiable information in many different research studies, over a long period of time, without asking your permission again for any specific study covered by this form. This could help science and improve the health and lives of many people.

If you say "yes," Lone Star Circle of Care will store, use and share your identifiable information and may do so for the purpose of medical, scientific and other research, now and in the future, for as long as the information is needed for this purpose. We may share your identifiable information with research, academic, and medical institutions, drug and device companies, biotechnology companies and other researchers and organizations who may be working with these institutions on their research. **However, your personal information will <u>not</u> be published in any study or article.**

What happens if you say no?

If you say "no," researchers in most cases will have to ask your permission to use your identifiable information in any future research study. Because this may be difficult or impossible, it could make future scientific studies harder to do.

If you do not choose either "yes" or "no" after reading this form or talking to our staff, your identifiable information might still be used for some low risk research without your consent.

This form applies only to research that uses identifying information. Researchers can always use de-identified health information, without getting any person's consent and without asking an ethics committee for permission. De-identified information is health information that has your identifying data (e.g., name, date of birth, address) removed so that you cannot be identified.

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What types of research may be done?

Possible future research may include the following examples or similar types of research:

- Studying the causes and progression of different diseases and conditions
- Developing and testing methods to diagnose and treat different diseases and conditions
- Research about chronic diseases, such as high blood pressure and diabetes
- Research about mental health diagnosis and treatment
- Research about developmental disabilities
- Research about diet and nutrition
- Research about how social services and community organizations can help improve people's health and wellbeing; for example, how finding housing or obtaining legal services can help people get well
- Family planning and reproductive health research

In most cases you will not be told when your information is used as part of a specific research study. In some cases, you may be contacted for permission to participate in a study for a purpose that is not listed above.

Are there risks of harm?

The main risk in saying "yes" is that your private information could be shared inappropriately. We will do our best to protect your information from going to people who should not have it, including by removing information that could be used easily to identify you. There is some risk of this, but it is very small.

Another risk in saying "yes" is that your identifiable information could be used in a research project to which you might not agree, if you were asked specifically about it. The examples above should help you understand what to expect. Also, an independent research ethics committee will make sure that studies using your information based on this broad consent form are the types of research in the examples above.

Are there any benefits?

You may not personally benefit from saying "yes" in this form. However, your participation will help others by improving our understanding of health and disease, improving health care and treatment, and making care safer and more effective. For example, if a study shows that certain programs can improve people's lives, it can help these programs obtain resources so that more people are helped in the future.

How will my information be protected?

The personal information that can identify you is protected by federal privacy and security regulations issued under the Health Insurance Portability and Accountability Act ("HIPAA"). This section of this form advises you on your rights under these regulations.

If you say "yes" in this form, we may share your identifiable information with researchers in the future, as described above. We may also share your identifiable information with government and regulatory authorities that oversee research, and with committees and people at the entities conducting the research and in other places whose job is to review and oversee research.

Once we release your information, it may no longer be protected by HIPAA or other privacy laws from being used and shared without your consent.

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Your permission will last as long as we have a scientific and research need to use and share your identifiable information (including identifiable health information).

Studies that use your identifiable information will not publish information identifying you.

If you say no, will this affect your care at Lone Star Circle of Care?

No. Your consent is totally voluntary. If you say "no," you will not lose any access to health care or benefits because you said "no," and it will not change your relationship with your health care providers. No matter what you decide, your decision will not affect your rights to obtain medical care or other services.

Can you change your mind and reverse your decision to give this broad consent?

If you change your mind, contact the Privacy Officer at (512) 686.0152 or email privacy@lscctx.org. Lone Star Circle of Care will not allow new research uses of your identifiable information, but your information may still be used in studies that started before you changed your mind. If your identifiable information has already been given to another researcher, person, institution, or company, it may not be possible to limit their continued and new uses.

If you change your mind, Lone Star Circle of Care may still use your de-identified information in future research studies without your consent.

Will it cost anything?

No. Whether you say "yes," "no," or do not respond to this form, there are no costs to you.

Is there any payment or compensation for saying "yes"?

If you say "yes," your identifiable information may be used to create products or to deliver services, including some that may be sold and/or make money for others. If this happens, there are no plans to tell you, or to pay you, or to give any compensation to you or your family. Most studies do not lead to commercial products or to profit for anyone.

In some cases, you may be contacted to participate in additional research, and these studies may be paid. Those studies will have a separate consent form which you will need to sign.

If your de-identified information is used to create products or deliver services, there are no plans to pay you or give any compensation to you and your family.

If You Say "Yes," Will You Learn More about Your Health?

Because this is a broad consent, there are no plans to tell you about any specific research studies that might be done with your identifiable information, and there are no plans to give you any results from these studies. The results of any research studies will not be put into your medical record.

Whether you say "yes" or "no," Lone Star Circle of Care will continue to provide care for you and that information related to your care will be available in your Lone Star Circle of Care electronic medical record.

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What if you still have questions?

If you have any questions about this broad consent, please contact the Lone Star Circle of Care Privacy Officer at 512.686.0152 or privacy@lscctx.org.

If you want to report or have questions about an injury that you believe you or others have suffered as a result of agreeing to this broad consent, please contact the Lone Star Circle of Care Director of Quality at 512.686.0207.

Please ask us to explain anything in this form that you do not clearly understand. Please think about this broad consent and discuss it with family or friends before deciding to say "Yes" or "No."

If you say "YES"

- Your identifiable information will be stored, used and shared for the kinds of future research described in this broad consent form, without anyone asking permission for each new study.
- Identifying information may also be removed allowing this "de-identified" information to be used for any future research or other purpose.
- Researchers may contact you again later and ask to store, use and share your identifiable information for research not covered in this form.

If you say "NO"

- Your identifiable information will not be stored, used, or shared for the research described in this broad consent form.
- However, identifying information may still be removed allowing this "de-identified" information to be used for any future research or other purpose.
- Researchers may contact you again later and ask to store, use and share your identifiable information for research.

If you do not say "YES" or "NO"

- If you do not mark "yes" or "no" on this form (if you do not return it, or leave it blank), then it will be the same as if you were never asked to make a choice. This means your identifiable information may be used for future research if:
    - The researchers ask you to say yes to a specific research study, and you agree;
    - An ethics committee allows your identifiable information to be used in a study that is low risk to you without asking for your consent; or
    - Another legal exception applies.
- Identifying information may also be removed allowing this "de-identified" information to be used for any future research or other purpose.
- You may be contacted again later and asked to store, use and share your identifiable information for research, including for this broad consent.

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STATEMENT OF AGREEMENT OR REFUSAL

☐ **YES.** I have had the opportunity to review and ask questions about this agreement, and I agree to give my broad consent to the future research uses of my identifiable information. My participation is voluntary, and I may withdraw at any time without any penalty or loss of benefits to which I am entitled.

☐ **NO.** I have had the opportunity to review and ask questions about this agreement, and I do not agree to this broad consent.

_____
Your Printed Name

_____
Legally Authorized Representative's Printed Name (if applicable)

_____
Your Signature or Signature of Legally Authorized Representative