



Registration Form (PLEASE PRINT)

Patient Information:

First Name:		Last Name:		Middle:	
Date of Birth:		Email:		Phone Number:	
SSN:		Language:		Are you a US Military Veteran? Yes No	
May we leave a message? YES NO		Phone number to leave a message:			
May we text you? YES NO		Phone number to text:			
May we email you? YES NO		Email:			
Gender Identity: Choose not to disclose / Male / Female / Transgender Male / Transgender Female				Birth Sex:	
Sexual Orientation: Choose not to disclose / Straight / Lesbian or Gay / Bisexual / Don't know					
Street Address/ PO Box:		City:		State:	Zip:

Insurance Information (for grant purposes):

Do you have insurance? YES NO		Family Size		Yearly Income	
*please provide insurance card					
Do you have an advanced directive will?		Yes No			

In Case of Emergency

Name of Relative or Friend:		Relationship:		Phone number:	
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Please select your race. Check all that apply			Please select your ethnicity. Check all that apply		
<input type="radio"/> American Indian/Native Alaskan <input type="radio"/> Asian Indian <input type="radio"/> Black or African American <input type="radio"/> Chinese <input type="radio"/> Filipino <input type="radio"/> Guamanian or Chamorro <input type="radio"/> Japanese <input type="radio"/> Korean	<input type="radio"/> Native Hawaiian <input type="radio"/> Other Asian <input type="radio"/> Other Pacific Islander <input type="radio"/> Samoan <input type="radio"/> Vietnamese <input type="radio"/> White <input type="radio"/> Choose not to disclose	<input type="radio"/> Mexican, Mexican American <input type="radio"/> Chicano <input type="radio"/> Puerto Rican <input type="radio"/> Cuban <input type="radio"/> Hispanic, Latin, or Spanish origin <input type="radio"/> Not Hispanic <input type="radio"/> Choose not to disclose			

Living Status

Homeless Shelter	Transitional	Doubling up	Street	Other:
If you are a migrant farm worker, are you seasonal?		Yes	No	

Please list any family members/persons who may obtain or call and discuss your medical information.

Name: _____ Phone Number: _____ Relationship to patient: _____

Name: _____ Phone Number: _____ Relationship to patient: _____

ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage with _____ and assign directly to La Esperanza Clinic, Inc. all medical payments and benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered or reimbursed by my insurance carrier and/or its agents, including all coinsurance and deductibles. I agree, in the event of nonpayment or partial payment, to pay the outstanding balance owed to La Esperanza Clinic. I hereby authorize La Esperanza Clinic to (1) release any/all information to my health benefit plan regarding my illness and treatments, and (2) process insurance claims generated in the course of all medical services rendered to me.

MEDICARE ASSIGNMENT OF BENEFITS: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is true and correct. I authorize the release of any/all information concerning me to the Social Security Administration or its intermediaries or carriers, as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf and made payable to La Esperanza Clinic for medical services rendered to me. I understand that I am financially responsible for all charges not covered or reimbursed by Medicare, including all coinsurance and deductibles.

Patient/Parent/Guardian/Legal Representative Signature: _____ Date: _____



Consent to Treatment

Patient Name: _____ Date of Birth: _____ Age: _____

1. **I hereby authorize** the Physicians, Physician Assistants, Advance Practice Nurses, and any other Clinical Staff at this health center, at their service locations, and consent to routine diagnostic procedures, examinations, medical treatment, and dental treatment. This includes but is not limited to, routine laboratory work (such as blood, urine, and other studies), taking of x-rays, heart tracing, administration of medications, vaccinations, procedures, examinations, and treatment prescribed by the medical staff, physicians, mid-level providers, and dental staff. This may also include counseling services necessary to receive family planning services as defined by federal regulation. I understand that there are no guarantees being made to me concerning the results of my treatment or the effectiveness of an birth control methods.
2. **I understand** that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this. 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. Release of Information: **I authorize La Esperanza Clinic** to release medical and/or dental information to third-party insurance carriers for the purpose of filing insurance claims related to (his/her) medical and/or dental care.
4. **I further authorize** the release of medical and/ or dental information about my treatment here to my (his/her) doctor or anyone designated by me.
5. **I understand that** "Patients' Rights & Responsibilities" are available to me upon request.
6. **I understand that** this consent form will be valid and remain in effect as long as I attend La Esperanza Clinic. I have been given an opportunity to ask questions about the services to be provided. I believe that I have sufficient information to give this informed consent.

Patient Signature

Date

If the patient is 17 years or younger or unable to consent, complete the following:

The Patient is unable to consent because _____

Signature of Person Giving Consent

Print

Relationship to Patient: Parent Guardian Other _____



Informed Consent for Telemedicine and/ or Telehealth

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

Name of person giving consent if different from the patient: _____

[Print Name]: _____

Relationship to Patient: Self Parent Guardian Other: _____

In order to better serve the needs of the community, some healthcare services are available from the center via telemedicine and telehealth. Telemedicine medical services and telehealth services are health care services delivered by physicians and health professionals to patients located at different physical locations using telecommunications or other information technology. Telecommunications or other information technology may also be used for virtual check-ins, e-visits, initial evaluations, screenings, and pre and post-visit communication by center staff. Providers may include, but are not limited to, Physicians, Advanced Practice Registered Nurses, Physician Assistants, Professional Counselors, Marriage and Family Therapists, Clinical Social Workers, and Psychologists.

Information shared may include patient medical records, medical images, medical audio or video files, two-way audio and video, and output data from medical devices. The systems used by the center to transmit and receive this information will incorporate network and software security protocols intended to protect the confidentiality of the patient's identity and information.

I hereby voluntarily consent to authorize the center's healthcare providers to provide healthcare services to me via telemedicine and/ or telehealth.

I understand the following:

- The same standard of care applies to health care services delivered via telemedicine and/ or telehealth as applies to an in-person visit.
- The laws that protect the privacy and confidentiality of health care information apply to health care services delivered via telemedicine and/ or telehealth.
- I will not be physically in the same room as my healthcare provider. I will be notified of, and my consent obtained, for anyone other than my healthcare provider present in the room.
- There are certain hazards and risks connected with all forms of treatment, regardless of the medium used, and my consent is given knowing this.
- There are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the telecommunications or information technology is not adequate, the visit may be discontinued.



- I have the right to refuse to participate or decide to stop participating in a telemedicine/ telehealth visit at any time.
- I understand that this visit may need to be converted into an in-person visit for situations and/or cases that require a physical exam in order to determine a diagnosis and for appropriate treatment and care.
- The center and the center's healthcare providers have no liability or responsibility for the accuracy or completeness of the medical information submitted to them or for any errors in its electronic transmission.
- I may consent to my medical record or a report containing an explanation of the treatment provided being sent to my primary care physician.
- This informed consent for telemedicine and/or telehealth 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.

Signature of Patient or Legal Representative

Date

LA ESPERANZA
APPROVED
AUTHORIZED FOR USE



PATIENT RESPONSIBILITIES

CALL TO CANCEL AND RESCHEDULE APPOINTMENTS: If you cannot come to your scheduled appointment, please call **(325) 658-5339** as soon as possible to cancel and reschedule. Not canceling wastes an appointment time that can be used by another patient.

NOT CALLING TO CANCEL APPOINTMENT POLICY: Our policy is that after the 3rd time a patient does not call to cancel or reschedule an appointment, they may be put on a “Walk in Only” status. They may come as a “walk-in” and wait to be seen if the schedule allows.

REMINDER CALL: LEC calls patients to remind and confirm the appointment date and time. Please be sure we have your correct phone number on file and let us know if you **do not** want us to leave a message on your answering machine.

AFTER-HOURS/ WEEKENDS: If you have questions or concerns after hours or on weekends, please call (325) 658-5339. We offer a 24-hour, 7 days a week, 365 days a year nurse advice line which is answered by a registered nurse.

IF YOU HAVE AN EMERGENCY, PLEASE CALL 9-1-1. MEDICATIONS: Please bring

your medications to each visit and inform the nurse of any refill needs. **PAYMENT:** Payment is expected at

each visit. LEC strives to provide quality care at affordable prices and depends on your good faith effort to pay for the services you receive. If you cannot afford our fees, you may apply for a Sliding Fee Scale discount. A payment plan may be arranged if necessary.

CONTACT INFORMATION: Please inform the patient registration staff of any changes in your phone number, address, or insurance so we can quickly and correctly process your payment and arrange any referrals to specialists. If you are not enrolled in MyChart please ask patient registration staff to help get you set up.

ZERO Tolerance Policy: LEC practices Zero Tolerance of Abuse, Harassment or Violence. If any patient behaves in a violent or threatening manner, LEC has the right to terminate care immediately. LEC will not tolerate any harassment for the sake of employees and all patients involved.

Patient Signature

Date

Patient Name (Printed)



SLIDING FEE SCALE DISCOUNT PROGRAM

La Esperanza Clinic, Inc. offers a Sliding Fee Scale (SFS) Discount program for uninsured and under-insured patients. The clinic determines slide eligibility by following HHS Federal Poverty Guidelines.

What is not covered under the Sliding Fee Scale Discount Program?

- Out of Scope Services (Services that are not considered medically necessary)
- Medications - Prescriptions
- Outside laboratory/radiology fees
- Supplies
- Injectables outside of the standard of care
- Patients above 200% of the Federal Poverty Guidelines are not eligible for Sliding Fee Scale Discounts

We request payment of the Sliding Fee Scale Discount Fee at the date of service.

Services not covered may be covered by enrolling and qualifying into other health coverage programs. Please contact our Outreach Department at (325)658-5339 if you need assistance with any of the following:

- Medicaid/Medicare Enrollment
- Market Place Insurance Enrollment
- Services not covered sliding fee scale program
- Food
- Transportation to and from medical appointment

SLIDING FEE SCALE PROGRAM CONDITIONS No patient is denied services for inability to pay.

1. To qualify for the Sliding Fee Scale (SFS) Discount Program, you must bring your family's proof of income within 7 days.

a. Proof of Income: 1 month of current pay stubs, most current tax forms, a letter from employer, documents verifying amount of income from other sources, ex. Unemployment, SSI, alimony, child support etc.

b. Family: Patient, Spouse (including common law and same sex marriage as recognized by U.S. Jurisdiction), and Children up to age 18 or up to age 21 if a high school or college student.

c. If you do not have your proof of income at your first visit/appointment, you may estimate your family's current gross annual income but must bring documentation to the health center within 7 days.

2. If your proof of income is eligible, you will receive a discount through January 31st. Patients must re-apply for the sliding fee scale program after January 31st of the following year.

3. You may be eligible for Medicaid, Medicare, or subsidized health coverage programs. Although it is not a requirement to enroll in our Sliding Fee Scale Discount Program, we can help you make an appointment with a certified enrollment counselor to determine whether you are eligible for these programs. Please contact our Outreach Department at (325) 658-5339.

4. If you fail to bring us your proof of income within the specified date below, you will be responsible for the full cost of the visit and any following visits until income is provided.

I understand that I need to bring in my Proof of Income by _____ to receive my Sliding Fee Scale Discount Status. _____ Patient Initials. No patient is denied services for inability to pay.

I decline the Sliding Fee Discount Program at this time, and accept responsibility for charges.

Print Name: _____ Signature: _____ Date: _____



SLIDING FEE SCALE APPLICATION FORM

Applying for health coverage is NOT a prerequisite for Sliding Fee Scale discount eligibility.

Date:	Name:	DOB:
Mailing Address:	City & State:	Zip:
Cell Phone:	Work Phone:	Home Phone:

Would you like to schedule an appointment with a Certified Enrollment Counselor to see if you and/or household members are eligible for Medicaid, Medicare or subsidized health insurance? Yes No

Please list all immediate family members and persons living in your household (spouse or life partner and children that are dependent on family income. Please do not include guests, elderly parents or roommates.

Name	Sex	Date of Birth	"X" if NO health insurance	Name of Insurance Carrier
(SELF)				

Please tell a staff member if you have more household family members to add.

What is your gross family income BEFORE deductions? Please include below all working adults, above age 19:

Name of household members receiving income	Estimated Annual Income Monthly Income X 12	Source(s) of Income	Proof of Income Date Requested Date Verified	LEC Staff Notes



I certify that the income and household composition information is true and correct to the best of my knowledge. I have read the Sliding Fee Scale (SFS) Discount Application, and I will abide by all SFS Discount requirements.

- 1. I understand and agree that I am responsible for notifying La Esperanza Clinic of any changes in my household size or income by completing a new application.**
- 2. I understand that my SFS Approval is good through January 31st with all required documents.**
- 3. I understand that I am responsible for paying my office visit co-pay at the time of service along with any slide ineligible charges that I may incur during my visit.**
- 4. I understand that if I do not provide all required documentation within 7 days of this application, I will not be approved for a Sliding Fee Discount and I will be responsible for all current and future office visit charges.**

Applicant Signature: _____

Date: _____

Please email your proof of income to: frontdesk@esperanzahealth.org

STAFF USE ONLY:

LEC Staff:	Date:
All documentation received: YES NO PENDING:	If yes, was POI received within 7 days? YES NO
Sliding Fee Scale: A B C D	No Discount



Sliding Fee Scale Eligibility Results

Based on your annual income of _____ and a family size of _____, you qualify for SFS level _____
\$ (7 days - Pending Status Start _____, End Date: _____)
Date: _____

Based on your annual income of \$ _____ and a family size of _____, you qualify for SFS level _____
(End Date: January 31, _____).

For each office visit, patient will pay:

- \$ _____ Medical
- \$ _____ Lab
- \$ _____ Behavioral Health & Nutrition Services
- \$ _____ Dental
- \$ _____ Procedures (IN CLINIC)
- \$ _____ Radiology

***Patients are responsible for additional costs not covered under SFS.**

***Patients will be notified in writing before ineligible charges are provided.**

You may also be eligible for the following health coverage programs. To find out if you qualify, contact our Certified Enrollment Counselors at (325)658-5339.

- Medicaid
- Medicare
- Chip
- Healthy Texas Women
- Subsidized Health Coverage

Patient Signature

Date

LEC Approval Signature

Date

La Esperanza Clinic	SLIDING FEE APPLICATION	Date:	
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FAMILY SIZE

Name	LEC Patient	DOB	Marital Status	Relationship

FAMILY INCOME

	Income Provided	Monthly	Annual
WEEKLY GROSS INCOME	\$		
BI-WEEKLY GROSS INCOME	\$		
SEMI-MONTHLY GROSS INCOME	\$		
MONTHLY GROSS INCOME	\$		
ANNUAL GROSS INCOME	\$		
Total Gross Income			

Number in Household	A	B	C	D	F No Discount; 100% of charges
	Under 100% FPL	>100%-149% FPL	>150%-179% FPL	>180%-200%	>200% FPL
1	\$15,960	\$23,939	\$28,727	\$31,920	\$31,921
2	\$21,640	\$32,459	\$38,951	\$43,280	\$43,281
3	\$27,320	\$40,979	\$49,175	\$54,640	\$54,641
4	\$33,000	\$49,499	\$59,399	\$66,000	\$66,001
5	\$38,680	\$58,019	\$69,623	\$77,360	\$77,361
6	\$44,360	\$66,539	\$79,847	\$88,720	\$88,721
7	\$50,040	\$75,059	\$90,071	\$100,080	\$100,081
8	\$55,720	\$83,579	\$100,295	\$111,440	\$111,441
9	\$61,400	\$92,099	\$110,519	\$122,800	\$122,801
10	\$67,080	\$100,619	\$120,743	\$134,160	\$134,161

	A	B	C	D	F No Discount; 100% of Charges
Scale/Charge per visit Medical	\$35	\$45	\$65	\$85	100% of Charges
Lab	\$15	\$20	\$25	\$30	100% of Charges
Behavioral Health/Nutrition	\$10	\$15	\$20	\$25	100% of Charges
Dental	\$75	\$85	\$90	\$100	100% of Charges
Procedures**	\$90	\$95	\$100	\$105	100% of Charges
Radiology	\$75	\$80	\$85	\$90	100% of Charges

* For families/Households with more than 10 persons, add \$5,380 for each additional person
 **Income guidelines based off of 2026 Federal Poverty Guidelines

Presumptive Status			Annualization		
Estim. Income			Gross Income:		
Family Size			Family Size		
Effective Date	Begin	End	Effective Date	Begin	End
Slide Category			Slide Category		
Application Denied					

IF DOCUMENTATION IS NOT PROVIDED WITHIN 7 DAYS, YOU WILL BECOME RESPONSIBLE FOR 100% OF ALL CHARGES

I certify that the income and household composition information is true and correct to the best of my knowledge. I have read the Sliding Fee Scale (SFS) Discount Application, and I will abide by all SFS Discount requirements.

Patient Signature

Date

LEC Staff

Date

