La Esperanza Clinic, Inc.

After Hours Information

Thank you for choosing us for your healthcare needs.

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.

If you are not currently enrolled in our patient portal, please see a registration clerk to get enrolled.

PATIENT REGISTRATION

La Esperanza Clinic, Inc.

PATIENT

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER	AGE	DATE OF BIRTH

MAILING ADDRESS	APT NO

CITY	STATE	ZIP	COUNTY

PRIMARY CARE PROVIDER_____

IF YOU DO NOT HAVE ONE, WOULD YOU LIKE TO BE ASSIGNED TO A PRIMARY CARE PROVIDER? ☐ YES ☐ NO

PRIMARY DENTAL CARE PROVIDER_____

IF YOU DO NOT HAVE ONE, WOULD YOU LIKE TO BE ASSIGNED TO A PRIMARY DENTAL PROVIDER? ☐ YES ☐ NO

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

HOME PHONE	CELL PHONE	EMAIL ADDRESS

BIRTH SEX: ☐ MALE ☐ FEMALE

CURRENT GENDER: ☐ MALE ☐ FEMALE ☐ UNDIFFERENTIATED

GENDER IDENTITY
☐ 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
☐ 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:
☐ ENGLISH
☐ SPANISH
☐ OTHER: _____

MARITAL STATUS:
☐ MARRIED
☐ SINGLE
☐ DIVORCED/SEPARATED
☐ WIDOWED

ARE YOU A US MILITARY VETERAN? (DOES NOT INCLUDE ACTIVE DUTY MILITARY SERVICE)
☐ YES ☐ NO

PUBLIC HOUSING? ☐ YES ☐ NO

HOW ARE YOU LIVING?
☐ DOUBLED UP(LIVING OTHERS) ☐ ON THE STREET
☐ IN A HOMELESS SHELTER ☐ TRANSITIONAL HOUSING

MIGRANT FARM WORKER; IF YES, CHOOSE ONE OF THE FOLLOWING:
☐ SEASONAL ☐ MIGRANT

DO YOU HAVE AN ADVANCED DIRECTIVE WILL?
☐ YES ☐ NO

DO YOU HAVE HEALTH INSURANCE: ☐ YES ☐ NO

☐ MEDICARE ☐ INDIGENT ☐ PRIVATE INSURANCE
☐ MEDICAID ☐ WORKER'S COMP ☐ OTHER:_____

OCCUPATION: _____

EMPLOYER NAME: _____

FAMILY SIZE	YEARLY INCOME	SIGN IF REFUSE TO PROVIDE PROOF OF INCOME

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 La Esperanza Clinic, Inc. (LEC) to release any medical or other information needed to process all insurance claims. I authorize payment of insurance benefits directly to LEC. 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*

La Esperanza Clinic, Inc.

CONSENT FOR TREATMENT

Name of Patient: _____ Date of Birth: _____

Name of person giving consent if different from Patient: _____

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 centers 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 is a separate consent form that I may be asked to sign to be tested for infectious conditions.

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.

CONSENT PROVISIONS

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 above 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 midlevel providers (Physician Assistants and Advanced Practice Registered Nurses) 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) that require such.
5. I hereby voluntarily give my consent to Treatment at the Center.

_____ _____

Signature of Patient/Legal Representative Date

_____ _____

Signature of Witness Date

La Esperanza Clinic, Inc.

PATIENT AND CENTER RIGHTS, RESPONSIBILITIES, AND PRIVACY NOTICE

I acknowledge I have received the Patient and Center Rights, Responsibilities, and Privacy Notice of La Esperanza Clinic, Inc.

_____ _____
Signature of Patient/Patient Representative Date

_____ _____
Signed by Patient Representative, indicate Relationship to Patient Date

If it is not possible to obtain the individual's Acknowledgement, describe the good faith efforts made to obtain the individual's Acknowledgement, and the reasons why the Acknowledgement was not obtained.

_____
_____
_____

_____ _____
Signature of Center Representative Date

_____ _____
Print Name of Center Representative Date

_____ _____
Print Title of Center Representative Date

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

Name: _____ Name: _____

Phone Number: _____ Phone Number: _____

Relationship to Patient: _____ Relationship to Patient: _____

IF THE PATIENT IS A MINOR:

Are the family members/persons listed above authorized to bring your child to their appointment? ☐ YES ☐ NO

Are these authorized family members/persons allowed to make any medical treatment decisions as suggested by their provider at the time of the visit? ☐ YES ☐ NO

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at La Esperanza Clinic, Inc. Consent will expire on _____ or in 365 days from the date listed above.

_____ _____
Patient Signature or Legal Representative Date

La Esperanza Clinic, Inc.

SLIDING FEE APPLICATION

PATIENT INFORMATION		DATE:		
First Name:	Middle Initial:	Last Name:		
Mailing Address: Apt #	City:		State:	Zip Code:
Home Phone:	Cell Phone:			Date Of Birth:

Have you applied for Texas Medicaid? YES NO Do you have Medicare? YES NO

If NO, would you like to apply for Texas Medicaid? YES NO

Are you able to obtain health insurance through an employer or other means? YES NO

Would you like to speak with someone about enrolling in private insurance? YES NO

HOUSEHOLD INCOME INFORMATION					
Name of **ALL** household Members:	Date of Birth:	Relationship:	Gross Income: (before taxes)	How Often:	What Type: Circle One
		SELF			Empl Wages Gift/Donations SSI Child Support
					Empl Wages Gift/Donations SSI Child Support
					Empl Wages Gift/Donations SSI Child Support
					Empl Wages Gift/Donations SSI Child Support
					Empl Wages Gift/Donations SSI Child Support
*For 6 or more household members, ask for assistance.	**TOTAL QUALIFYING HOUSEHOLD MEMBERS:**				

I certify that all information provided is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services, which are rendered to me by Esperanza Health & Dental Centers. I understand that submission of false information will automatically disqualify me from any type of assistance.

I understand that if I am applying for financial assistance and do not have proof of income with me, I will be required to pay for 100% of charges at the time of service at Esperanza Health & Dental Centers . I will also be responsible for 100% of charges at the time of service for subsequent visits until I provide proof of income.

Name (Print) _____ Signature _____ Date ___/___/___

FOR OFFICE USE ONLY:

Qualifies for:_____slide

Medical: A-$40 Nominal Fee B-50% discount C-30% discount D-10% discount F-0% discount
Dental: A-$40 Nominal Fee B-60% discount C-40% discount D- 20% discount F-0% discount

Date of determination:_____ Signature of person making eligibility determination:_____

La Esperanza Clinic, Inc.

MEDICAL HISTORY

Name of Physician/Location: _____

When was your last physical? _____ Are your immunizations up to date? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, for what reason? _____

Are you currently taking any medications/drugs/pills? ☐ Yes ☐ No

LIST CURRENT MEDICATIONS & DOSES YOU ARE TAKING:					
MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

Are you allergic or have an adverse reaction to? ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Aspirin

Are you sensitive or allergic to latex? (I.e. experienced itching, rash or wheezing after using latex gloves or handling a balloon? ☐ Yes ☐ No If yes, please explain: _____

Have you had any unusual or unexplained reactions during a surgical procedure? ☐ YES ☐ NO

If yes, please explain: _____

Do you have any of the following listings below?

- ☐ Abnormal Blood Pressure
- ☐ Alcohol Addiction
- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Congenital Heart Disease
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Heart Disease/Surgery
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Hemophilia
- ☐ Hepatitis __A __B __C
- ☐ High Cholesterol
- ☐ HIV Positive/AIDS
- ☐ Kidney Problems
- ☐ Learning Disability
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Prolonged Bleeding
- ☐ Prosthetic Implants
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Removal of Spleen
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

La Esperanza Clinic, Inc.

Have you had any other serious illness, hospitalizations or accidents? ☐YES ☐NO

If yes, please explain: _____

Do you currently use the following tobacco products? ☐ Cigarettes ☐ Cigars ☐Pipe ☐ Chew ☐None

If yes, for how long? _____

Have you used tobacco products in the past? ☐YES ☐NO If yes, how long ago did you quit? _____

Do you drink alcoholic beverages? ☐ YES ☐NO If yes, how much? _____

WOMEN ONLY: Are you pregnant? ☐YES ☐NO Due Date: _____

Are you nursing? ☐YES ☐NO Do you take birth control medications? ☐YES ☐NO

Do you anticipate becoming pregnant? ☐YES ☐NO

MEDICATION ALLERGIES-_____

PREFERRED PHARMACY- _____

DENTAL HISTORY

Date of last dental visit: _____

Do your gums bleed while brushing? ☐ YES ☐NO

Are your teeth sensitive to hot or cold liquids/foods? ☐ YES ☐NO

Are your teeth sensitive to sweet or sour liquids/foods? ☐YES ☐NO

Do you feel pain to any of your teeth? ☐YES ☐NO

Do you have any sores or lumps in or near your mouth? ☐ YES ☐ NO

Have you had any head, neck or jaw injuries? ☐ YES ☐NO

Do you have frequent headaches? ☐YES ☐NO

Do you clench or grind your teeth? ☐YES ☐NO

Do you bite your lips or cheeks frequently? ☐ YES ☐ NO

Have you ever experienced any of the following?

☐Clicking in jaw ☐Pain (joint, ear, side of face) ☐Difficulty in opening or closing mouth ☐ Difficulty in chewing

Have you had any orthodontic work? ☐ YES ☐ NO

Have you ever had prolonged bleeding following extractions? ☐ YES ☐ NO

Have you ever had instruction on the correct method of brushing your teeth? ☐ YES ☐ NO

Have you ever had instructions on the care of your gums? ☐ YES ☐ NO

La Esperanza Clinic, Inc.

PATIENT AND CENTER RIGHTS, RESPONSIBILITIES, AND PRIVACY NOTICE

Welcome to the center.

When it comes to health care, whether you're seeking wellness, recovering from illness or managing a chronic condition. It's a cycle of staying well, getting well and being well. If you deal with these health situations in a long-term relationship with a trusted medical provider, then you've found your Patient Centered Medical Home here with us.

Our goal is to provide quality health care to people in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. The center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read and sign this statement and ask us questions you might have.

A. Human Rights

You have a right to be treated with respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age, Vietnam era veteran status, or other grounds as applicable federal, state and local laws or regulations.

B. Payment For Services

1. You are responsible for giving staff accurate information about your present financial status and any changes in your financial status. The staff need this information to decide how much to charge you and/or so they can bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, you will be charged a discounted fee.

2. You have a right to receive explanations of the center's bill. You must pay, or arrange to pay, all agreed fees for medical services, with the exception of dental services, which are provided on a prepaid basis. If you cannot pay right away, please let staff know so they can provide care for you now and work out a payment plan.

3. Federal law[1] prohibits the center from denying you primary health care services which are medically necessary solely because you cannot pay for these services.

C. Privacy

You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private. Only legally authorized persons may see your medical records unless you request in writing for us to show them to, or copy them for, someone else. In certain instances, the center may be required to report to the Texas Department of State Health Services regarding your health condition or disease status. A complete discussion of your privacy rights will be given to you along with this document and is named the center's Notice of Privacy Practices. Staff will request that you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices sets forth the ways in which your medical records may be used or disclosed by the center and the rights granted to you under the Health Insurance Portability and Accountability Act ("HIPAA").

D. Health Care[2]

1. You are responsible for providing the center complete and current information about your health or illness, so that we can give you proper health care. You have a right, and are encouraged, to participate in decisions about your treatment.

2. You have a right to information and explanations in the language you normally speak and in words that you understand. You have a right to information about your health or illness, treatment plan, including the nature of your treatment; its expected benefits; its inherent risks and hazards (and the consequences of refusing treatment); the reasonable alternatives, if any (and their risks and benefits); and the expected outcome, if known. This information is called obtaining your informed consent.

3. You have the right to receive information regarding "Advance Directives." If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to your legally authorized representative.

[1] For more on the Sliding Fee Scale see chapter 9 of the Health Center Compliance Manual and the relevant Sliding Fee Discount Program protocol in the Health Center Program Site Visit Protocol. Last accessed March 2018.
[2] This policy and procedure is designed to be consistent with the intent of the requirements for the Joint Commission Standards RI.01.01.01, RI.01.01.03, RI. 01.02.01, RI.01.03.01, CAMAC Update 1, July 2017.

4. You are responsible for appropriate use of center services, which includes following staff instructions, making and keeping scheduled appointments, and requesting a "walk in" appointment only when you are ill. Center professionals may not be able to see you unless you have an appointment. If you are unable to follow instructions from the staff, please tell them so they can help you.

5. If you are an adult, you have a right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of your refusing such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed." You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in your best interest, you may be asked to sign a Refusal to Permit Medical Treatment or Services form or Against Medical Advice form (as appropriate).

6. You have a right to health care and treatment that is reasonable for your condition and within our capability, however, the center is not an emergency care facility. You have a right to be transferred or referred to another facility for services that the center cannot provide. The center does not pay for services that you receive from another healthcare provider.

7. If you are in pain, you have a right to receive an appropriate assessment and pain management, as necessary.

E. Center Rules

1. You have a right to receive information on how to appropriately use the center's services. You are responsible for using the center's services in an appropriate manner. If you have any questions, please ask us.

2. You are responsible for the supervision of children you bring with you to the center. You are responsible for your children's safety and the protection of other patients and our property.

3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments you may be subject to disciplinary action pursuant to the center's policies and procedures.

F. Complaints

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Staff will tell you how to file a complaint. If you are not satisfied with how the staff handles your complaint, you may complain to the center's Board of Directors.

2. If you make a complaint, no center representative will punish, discriminate or retaliate against you for filing a complaint, and the center will continue to provide you services.

G. Termination

If the center decides that we must stop treating you as a patient, you have a right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find other health care services. However, the center can decide to stop treating you immediately, and without written notice, if you have created a threat to the safety of the staff and/or other patients. You have a right to receive a copy of the center's Termination of the Patient and Center Relationship Policy and Procedure.

Reasons for which we may stop seeing you include:

1. Failure to obey center rules and policies, such as keeping scheduled appointments;
2. Intentional failure to accurately report your financial status;
3. Intentional failure to report accurate information concerning your health or illness;
4. Intentional failure to follow the health care program, such instructions about taking medications, personal health practices, or follow up appointments, as recommended by your healthcare provider(s), and/or
5. Creating a threat to the safety of the staff and/or other patients.

H. Appeals

If the center has given you notice of termination of the patient and center relationship, you have the right to appeal the decision to the Board. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.