

Date: \_\_\_\_\_  
 Site: \_\_\_\_\_  
 Client # \_\_\_\_\_  
 New \_\_\_ Return \_\_\_

**Matagorda Episcopal Health Outreach Program Inc.**  
 101 Ave F. North  
 Bay City TX 77414  
 Phone: (979) 245-2008 • Fax: (979) 245-0744

**PAYMENT IS EXPECTED AS SERVICES ARE RENDERED**

Thank you for choosing our office.  
 In order to serve you properly we will need the following information.  
 (PLEASE PRINT using black ink)

Patient Name Nombre del paciente		Last Apellido	First Nombre	MI	Birthdate Fecha de Nacimiento	Sex Sexo	Marital Status Estado Marital
Address Domicilio		City Ciudad	State Estado	Zip Zona Postal	Home Phone Teléfono		
Social Security # Seguro Social		Driver's License # Numero de licencia		e-Mail Address correo electrónico			
If child, Parent or Guardian Name Si es menor de edad, que es el nombre de los padres			Parent/Guardian Social Security # Seguro Social		Parent/Guardian Birthdate Fecha de Nacimiento	Sex Sexo	Marital Status Estado Marital

Name of employer/ occupation Nombre de empleador		Address Domicilio		Business Phone Teléfono	
Do you have medical insurance? (Cuenta Ud. con aseguranza médica?)		If no, how do intend to pay? Si no, como piensa pagar?		Ins. Co. Name & Address Nombre y domicilio de aseguranza	
Subscriber Name Nombre del suscriptor		Policy Number Numero de la póliza	Group Number Número de grupo	Is it through your employer? ¿Es a través de su empleador?	
Name of Spouse Nombre de Espos(a)		Spouse Birthdate Fecha de Nacimiento		Spouse Social Security Number Seguro Social	
Is there secondary insurance, spouse 2nd carrier? ¿Hay secundaria empresa aseguradora, de 2 de cónyuge?		Name & address of spouse employer Nombre y dirección del empleador del cónyuge			Business Phone
Secondary insurance name & address Nombre de seguro secundarios & dirección		Policy # or I.D. Política # o identificación		Group Number Número de grupo	
Medicaid Number Número de Medicaid		Medicare Number Número de Medicare			
Person financially responsible for this account Quien es la persona responsable por esta cuenta		Address Domicilio		Relationship to Patient Qué relación tiene con el paciente?	

<b>Why are you here today?</b> Porque esta aqui hoy?			
Attending School? Esta atendiendo escuela actualmente?	Yes ___ No ___	Grade _____	Last Grade Completed: _____ Último grado de estudio
Ethnicity: Etnicidad White ___ Black ___ Hispanic ___ Asian ___ Other? _____			
How did you find out about MEHOP? Como se enteró de MEHOP? _____			
Do you have a Church home? Yes ___ No ___		If yes, where? _____	
Es usted miembro de una Iglesia?		Si, indique donde? _____	

Person to contact in case of an emergency? En caso de emergencia, a quien debemos notificar	
Name _____ Nombre	Address _____ Domicilio
Phone # ( ) _____ - _____ Teléfono	Relationship to patient? _____ Que relación tiene con el paciente?

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all changes, regardless of insurance coverage. By signing below, I am indicating that the information above is accurate to the best of my knowledge. My signature acknowledges that I voluntarily consent to examination, testing procedures, and treatment by the Matagorda Episcopal Health Clinic. I am aware that information may be shared with other agencies for referral purposes or in delivering services.

Autorizo esta oficina a liberar cualquier información necesaria para facilitar reclamos al seguro. Entiendo que soy responsable de todo carga, a pesar de la suguranza. Cuando yo firme abajo, yo indico que la información es exacto al mejor de me concimiento. Voluntariamente y con mi firma doy consentimiento a los exámenes y servicios que voy a tomar de el Matagorda Episcopal Health Clinica. Estoy enterado que la información puede ser compartida con otras agencias para referencias u otros servicios.

Signature (Parent or Guardian)  
(Firma)

Date  
(Fecha)

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with a call-back number and name only<br><input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number and name only<br><input type="checkbox"/> Cell Phone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number and name only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work address<br><input type="checkbox"/> O.K. to fax to this number _____<br><input type="checkbox"/> Other _____<br>_____<br>_____ |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below will constitute and adequate record. Uses and Disclosures for treatment, payment and healthcare operations may be permitted without prior consent in an emergency.

### Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure / Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) check this box if the disclosure is authorized

(2) Type Code: T=Treatment Records P=Payment Information O=healthcare Operations

(3) Enter how disclosure was made: F=Fax P=Phone E=Email M=Mail O=Other

**MATAGORDA EPISCOPAL HEALTH OUTREACH PROGRAM  
PATIENTS' AND CENTER'S RIGHTS AND RESPONSIBILITIES**

Welcome to the Matagorda Episcopal Health Outreach Program (MEHOP). Our goal is to provide quality health care to qualified persons in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. MEHOP also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide health care for you. Please read this statement and ask us any questions you may have about our agency.

**Human Rights**

1.  You have a right to be treated with respect and dignity regardless of race, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age (over 40), Vietnam era veteran status, or other grounds not permitted by applicable federal, state and local laws or regulations.

**Payment for Services**

2.  You are responsible for giving us accurate information about your present financial status and any changes in your financial status. We need this information to establish your fee and/or so we 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 200%, you will be charged a discounted fee.
3.  You have a right to receive an explanation of the bill you receive for services. 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. Payment plans are made available for specific circumstances.
4.  Federal law prohibits MEHOP from denying you primary health care services, which are medically necessary, solely because of your inability to pay for these services. However, you are required to act in good faith and make payments for services.

**Assignment Of Insurance Benefits To Provider**

5.  I hereby request payment and assign any benefits due me under the terms of any policy or policies and/or under Title XV111 of the Social Security Act that may cover professional services rendered to the above name mentioned assignee.

**Privacy**

6.  You have a right to have your interviews, examinations and treatment in privacy. Your patient records (medical, dental, behavioral health, HIV, substance abuse) are also private. Only legally authorized persons may see your records unless you request in writing for us to show them to, or copy them for, someone else. A complete discussion of your privacy rights will be given to you along with this document and is named MEHOP's Notice of Privacy Practices. We ask that you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices sets forth the ways in which your patient records may be used or disclosed by MEHOP and the rights granted to you under the Health Insurance Portability and Accountability Act ("HIPAA"). If you have private insurance or are insured under Medicare or Medicaid, your insurer has the right to request patient records concerning a service that was billed to them by us.

**Health Care**

7.  You are responsible for providing us accurate, complete and current information about your health so that we can give you proper health care. You have a right and are encouraged to participate in decisions about your treatment.
8.  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.
9.  You have the right to receive information regarding "Advance Directives." (An Advance Directive is instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity, and appoints a person to make such decisions on their behalf.) 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. At this time would you like information about Advance Directives?  Yes  No  
If yes, additional information will be provided to you. If you state no, you may request information at another time.
10.  You have a right to receive information on how to appropriately use MEHOP's services. You are responsible for using MEHOP's services in an appropriate manner, which includes following our staff's instructions, making and keeping scheduled appointments, and requesting a "walk-in" appointment only when you are ill. MEHOP professionals may not be able to see you unless you have an appointment. If you are unable to follow the staff's instructions, please tell us so we can help you. Failure by you to follow medical advice may lead to the termination of the client physician relationship. If you are to be terminated from use of MEHOP, you will be notified. You may dispute this termination by following the appeal process. If you have any questions, please ask.
11.  If you are an adult, you have a right to refuse treatment or procedures to the extent permitted by applicable law and regulations. In this regard, you have the right to be informed of the risks, hazards and consequences of 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 refused 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).
12.  You have a right to health care and treatment that is reasonable for your condition and within our capability, however, MEHOP is not an emergency care facility. You have a right to be transferred or referred to another facility for services that we cannot provide. MEHOP does not pay for services that you receive from another healthcare provider. You are responsible for payment arrangements for services provided by another provider or entity outside of MEHOP.
13.  If you are in pain, you have a right to receive an appropriate assessment and pain management, as necessary.

**Center Rules**

14.  You are responsible for the supervision and safety of children you bring with you to MEHOP. You are responsible for your children's safety and the protection of other patients and our property. We are not responsible for children left unattended. Should any damages occur, you may be responsible for reimbursement of cost to repair or replace.
15.  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 asked to meet with MEHOP's Chief Executive Officer to determine the reason for your missed appointments and whether you can continue as a patient of MEHOP.

**Complaints**

16.  If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. You may request a Client Suggestion/Complaint Form to document your concerns. You shall receive a response from MEHOP by mail or phone regarding the outcome of your complaint or suggestion. If you are not satisfied with how the complaint is handled, you may complain to MEHOP's Board of Directors.
17.  You cannot be punished for filing a complaint, and we will continue to see you as a patient.

**Termination**

18.  If we decide to terminate our relationship with you, you have a right to advance notice that explains the reason for the decision, and you will be given thirty (30) days to find other health care services. However, MEHOP 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 MEHOP's Termination of the Patient and Center Relationship Policy and Procedure. Reasons to terminate may include: (1) failure to obey MEHOP rules, (2) intentional failure to report accurate financial information, (3) intentional failure to provide accurate health information, and (4) intentional failure to follow medical advice.
19.  If we decide to stop treating you as a patient, you have a right to appeal the decision to the Board of Directors or through the courts. Unless there is an emergency, we will not continue to see you as a patient while you are appealing the decision.

**Appeals**

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

Signature \_\_\_\_\_

Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Notice to Patient:**

MEHOP is required to provide you a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

\*\*\*\*\*

I acknowledge that I have received a copy of MEHOP's Notice of Privacy Practices.

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Please print your name here

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Signature

Date

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation, it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other (Please provide specific details)

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*Employee Signature*

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*Date*

**HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices**

**CONSENT TO TREATMENT**

I (for) undersigned patient, do hereby voluntarily consent to such health care involving routine diagnostic procedures and medical/dental treatment by my attending physician/dentist, his assistants or his designees. I am aware that the practice of medicine/dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this episode of care. I understand that the attending physician/dentist may not be an agent of the Matagorda Episcopal Health Outreach Program (MEHOP), and may have been granted privileges by MEHOP to practice medicine/dentistry and to use the facilities of MEHOP. I further understand that the nurses/hygienist and other technical staff at MEHOP do not practice medicine/dentistry, but carry out the orders of independent licensed physicians/dentists when providing treatment to patients at MEHOP.

**MEDICAL CARE**

Independent contractors furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, emergency room physicians, and others may bill directly for their services. MEHOP provides only general duty nursing care unless the physician orders that the patient be provided more intensive nursing care. If the patient's condition requires the service of a special duty nurse or sitter, this service must be arranged by the patient or patient's representative since MEHOP does not provide this special care. When protective side rails are placed on the patient's bed and raised for patient protection or when protective restraints are ordered, the patient assumes all risks of injury or damage if the patient refuses to permit raised side rails or restraints.

**CONSENT TO PHOTOGRAPH**

MEHOP is permitted to take pictures of the medical/dental or surgical progress involving the patient and to use same for scientific, educational or research purposes.

When patient is UNABLE to consent or is a MINOR, complete the following:

Patient is a MINOR ( \_\_\_\_\_ ) years of age, or is unable to consent because:

\_\_\_\_\_  
(Print reason patient is unable to consent)

\_\_\_\_\_  
Patient Signature or Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness, why patient is unable to consent

MATAGC \ EPISCOPAL HEALTH OUTREACH PROGR (MEHOP)  
HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone No. \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current medications and Dosages: \_\_\_\_\_

Do you smoke?  Yes  No How much: \_\_\_\_\_

Consume alcohol?  Yes  No How much: \_\_\_\_\_

Recreational Drug Use?  Yes  No How much: \_\_\_\_\_

Domestic Violence?  Yes  No Describe: \_\_\_\_\_

Describe your Current Job: \_\_\_\_\_

Check below if you are having any symptoms in the following areas and briefly explain:

- |                                 |                                      |                                      |                                           |                                                |
|---------------------------------|--------------------------------------|--------------------------------------|-------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Ears   | <input type="checkbox"/> Chest/Heart | <input type="checkbox"/> Head/Neck   | Recent Changes in:                        |                                                |
| <input type="checkbox"/> Nose   | <input type="checkbox"/> Back        | <input type="checkbox"/> Skin        | <input type="checkbox"/> Weight           | <input type="checkbox"/> Energy Level          |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Bladder     | <input type="checkbox"/> Circulation | <input type="checkbox"/> Ability to Sleep | <input type="checkbox"/> Other Pain/Discomfort |
| <input type="checkbox"/> Lungs  | <input type="checkbox"/> Bowel       |                                      |                                           |                                                |

Please explain any checked symptoms: \_\_\_\_\_

Patient Medical History: (for example, diabetes, heart disease, hypertension, asthma, etc) \_\_\_\_\_

Family Medical History: (for example, diabetes, heart disease, hypertension, etc)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Sisters/Brothers: \_\_\_\_\_

Children: \_\_\_\_\_

Health Maintenance:

When was your last:

Pap Smear: \_\_\_\_\_

Tetanus Shot: \_\_\_\_\_

Mammogram: \_\_\_\_\_

Pneumovax: \_\_\_\_\_

Colonoscopy: \_\_\_\_\_

Bone Density: \_\_\_\_\_

Prostate Exam: \_\_\_\_\_

Do you have a living will? \_\_\_\_\_ Patient Signature / Date: \_\_\_\_\_