Presidio County Health Services, Inc.

Presidio County Medical Clinic
Ph: 432-229-3030 Fx: 432-229-2500
501 O' Reilly St., P.O. Box 574
Presidio, Texas 79845

Family Health Services of Alpine
Ph: 432-837-4555 Fx: 432-837-4556
1707 N. 4th St.
Alpine, Texas 79830

Marfa Community Health Clinic
Ph: 432-729-1800 Fx: 432-729-1806
210 S. Summer St., P.O. Box 267
Marfa, Texas 79843

Please provide patient with a copy of the "Notice of Privacy Practices" at this time.

Date:_____

Last Name:_____ **First:**_____ **MI:**_____

Gender at time of birth: _____ **Date of Birth:**_____ **SS#**_____-_____-_____

Mailing Address:_____ **Physical Address:**_____

City: _____ **County:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____

Email:_____ **Marital Status:**_____

Spouse's Name:_____ **Contact Number:**_____

Other emergency contact name:_____ **Contact number:**_____

Pharmacy of Choice (Please circle one or write in your choice):

City Drug Store **Highland Drug** **Prescription Shoppe** **Other:**_____

Insurance: Please present insurance card each time of service. A copy will be placed in your file.

Primary Insurance:_____ **Secondary:** _____

Primary Policy Holder's Name: Last Name:_____ **First:**_____

Date of Birth:_____ **SS#**_____-_____-_____ **Relationship:**_____

Data collection tool, then shred.

Implemented October 2004, Revised March 19, 2012, Effective April 1, 2012 Revised September 29,2015, Effective November 25,2015 revised and effective January 26,2017
Garrison/Administration R&R

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Scan into Nextgen, then shred.

UDS Federal Reporting Requirements

Name:_____ **Date of Birth:**_____

1. **Number of people living in the home** _____.
2. **Are you a Veteran of the United States Military (please check one)?**

   ☐ Yes ☐ No

3. **Ethnicity (please check one):**

   ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Unreported/Refused to Report

4. **Race (please check one):**

   ☐ White ☐ Asian ☐ Black/African American
   ☐ More than one race ☐ Native Hawaiian ☐ Other Pacific Islander
   ☐ American India/Alaskan Native ☐ Unreported/Refuse to Report

5. **Primary Language (please check one):**

   ☐ English ☐ Spanish ☐ Other _____

6. **Shelter (please check one):**

   ☐ Reside in own home ☐ Reside with family/friend ☐ Homeless ☐ Public Housing ☐ Shelter

7. **Annual Income (please circle income applicable to your household):**

Equal to or less than:	Equal to or less than:	Equal to or less than:	Equal to or less than:	Equal to or less than:	Equal to or less than:	Greater than:	
$12,000	$18,000	$24,000	$30,000	$40,000	$50,000	$50,000	Prefer not to report

Gender Identity :

- ☐ Additional gender category or ~~other, please specify~~
- ☐ Choose not to disclose
- ☐ Female
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Male
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman

Sexual Orientation (cirle one):

Straight or heterosexual
Bisexual
Choose not to disclose
Don't Know
Lesbian, gay or homosexual
Something else, please describe

Data collection tool, then file.

Implemented October 2004, Revised March 19, 2012, Effective April 1, 2012 Revised September 29,2015, Effective November 25,2015 revised and effective January 26,2017
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UDS Federal Reporting Requirements (cont.):

Name:_____ **Date of Birth:**_____

Identifying Migrant Patients:

1. In the last two years (or prior to retirement), have you or a member of your family, as a primary source of income, worked as an agricultural laborer, planting, tilling or harvesting crops grown on the land such as fruit and vegetables?

☐ Yes ☐ No

If the answer is "No" please answer question 4.

If the answer is "Yes" please answer questions 2-4. This establishes them as an agricultural worker.

2. Have you or a member of your family moved in the past two years to another area (establish a temporary home) in order to perform agricultural labor?

☐ Yes ☐ No

A **"Yes"** to question #2 qualifies them as migrant farm workers.

3. Have you or a member of your family worked in the past two years in agriculture without the need to move away from your home?

☐ Yes ☐ No

A **"Yes"** to question #3 qualifies them as seasonal farm workers.

4. Have you or a member of your family stopped traveling to work in agriculture because of disability or old age?

☐ Yes ☐ No

A **"Yes"** to question #4 qualifies them as aged/disabled farm workers.

Data collection tool, then file.

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CONSENT PAGE

Authorization of Shared Information

_____ (Initial): In order to allow for the continuity of care my care, I, the responsible party, authorize Presidio County Health Services, Inc. to have two-way communications with other physicians, specialist, consultants, hospitals, diagnostic centers, pharmacies, durable medical equipment companies, and home health agencies.

Provider Level

_____ (Initial): I, the responsible party, authorize that it is acceptable to be seen by the nurse practitioner or physician assistant when the physician is not available or per my request.

_____ (Initial): I, the responsible party, authorize the resident, medical students, or midlevel student under the direction of this clinic to be present during my examination and treatment.

General Consent

_____(Initial): I, the responsible party, give permission to Presidio County Health Services, Inc. medical personnel to perform physical assessments or examination, conduct laboratory or other tests, give injections, medications, and other treatments and render other health services to the patient identified on this form. Additional consents may be required by the medical staff for additional treatment. This includes Hepatitis C Virus (HCV) and Human Immunodeficiency virus (HIV) screening as a routine opt-out process. I understand testing may include HIV/STD & Hep C testing unless I, the patient, decline (opt-out screening).

_____
(Initial): I, the responsible party, give permission to be seen by medical students and/or resident physicians who are under the supervision of PCHS clinicians.

Patient's Rights and Responsibilities

_____
(Initial): Presidio County Health Services, Inc. strives to offer you the highest quality health care in a courteous and timely manner. Presidio County Health Services, Inc. has provided me with a copy of **"PATIENT'S RIGHTS AND RESPONSIBILITIES."** They have also encouraged me to talk openly with the people caring for me.

Patient Acknowledgement of possible non-coverage by insurance carrier and patient responsibility

(Initial): I, the responsible party, understand that my insurance carrier or third party payer may not cover my office visit or procedures, tests, and treatment. I accept that I will be responsible for paying any services I receive that may not be covered by my insurance carrier, or third party payer. I authorize this office to release to the Social Security Administration and Centers for Medicare and Medicaid Services or any other commercial insurance company, any information needed for this claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits to this provider.

Notice of Privacy Practices

_____
(Initial): I, the responsible party, have been provided with the information explaining the **NOTICE OF PRIVACY PRACTICES.** This Notice describes how health information about me may be used and disclosed and how I can get access to this information. This policy has been given to me prior to signing this consent. Please review this carefully. **If you have not received the form or have any questions about our privacy policy, please do not hesitate to ask.**

_____ _____
Print Patient's Name Date of Birth

Person Authorized to Consent (if minor or not the patient):_____

Relationship to Patient:_____ Date of Birth of Authorized Person:_____

Signature_____ Date_____

Preventative Care Health Services Inc. (dba) Presidio County Health Services, Inc.
PCHS

Informed Consent for Telemedicine and/or Telehealth

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

Name of person giving consent if different from Patient:

[Print Name]: _____

Relationship to Patient: □ Self □ Parent □ Guardian □ Other: _____

In order to better serve the needs of the community, some health care 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 a different physical location 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 and voluntarily consent to authorize the center's healthcare providers to provide health care 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.

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 to a minimum, risks 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 receive health care services via telemedicine and/or telehealth.

_____

[Signature of Patient/Legal Representative]

Print Name: _____

Date/Time: _____

If signed by other than Patient, indicate relationship: _____

_____

[Signature of Witness]

Print Name of Witness: _____

Date/Time: _____

Interpreter/Translator to complete when applicable:

I have accurately and completely read/translated the foregoing document to:

_____ _____

[Insert the Patient's or Patient's Legal Representative's name]

in _____, the Patient's or Patient's Legal Representative's primary language. S/He understood all of the terms and conditions and acknowledged his/her agreement and consent thereto by signing the document in my presence.

Interpreted/Translated By: _____

[Signature of Interpreter/Translator]

Print Name of Interpreter/Translator: _____

Date/Time: _____

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: **1-800-201-9353**

For more information, please visit our website at **www.tmb.state.tx.us**.

OPTIONAL RELEASE OF INFORMATION FORM:

Please list family member or persons to whom we can release any and all of your medical information. This is entirely optional for your convenience, but may facilitate assisting you with appointments and understanding test results, etc.

Patient Name:_____ DOB:_____

Please list the family members or others person, if any whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name:_____ Relationship:_____

Phone #: Home:_____ Cell: _____ Work:_____

Name:_____ Relationship:_____

Phone #: Home:_____ Cell: _____ Work:_____

Name:_____ Relationship:_____

Phone #: Home:_____ Cell: _____ Work:_____

Name:_____ Relationship:_____

Phone #: Home:_____ Cell: _____ Work:_____

_____	___/___/20___	_____	___/___/20___
Signature of Patient or Personal Representative	Date (mm/dd/yyyy)	Witness	Date (mm/dd/yyyy)

_____

Relationship to Patient if not Self