Pediatric Associates
A Service of Community Healthcare Center

WELCOME TO PEDIATRIC ASSOCIATES…*Your child's health is our #1 priority!*

Pediatric Associates, a service of Community Healthcare Center, is proud to announce adoption of the "Medical Home" model of health care. This new, innovative, team-based approach to providing health care focuses on the partnership between the patient, and the Center's health care team. We will work together to coordinate the services your child needs and provide the best care possible.

HOURS

• **Pediatric Associates** • **Extended Hours**	**Monday through Friday** **Monday, Tuesday, Thursday**	**8:00 a.m. to 5:00 p.m.** **Open until 7:00 p.m.**

MINORS

Patients under 18 years of age must be accompanied by a parent or legal guardian in order to receive routine treatment. Legal guardians must bring proof of guardianship.

SERVICES and STAFF

Pediatric Associates offers the following services: pediatric care, counseling, lab, screening tests, immunizations, and eligibility assistance. The following services are performed at Community Healthcare Center at 200 MLK Jr. Blvd, Wichita Falls, TX: primary medical care, primary dental care, prenatal care, x-ray, and pharmacy.

PAYMENT FOR SERVICES RECEIVED

Fees charged are on a sliding fee scale based on your household income and family size. Payment should be made at the time of service. Pediatric Associates welcomes Medicare, Medicaid, STAR, STAR Kids, CHIP, most STAR plans, TRICARE, insurances, cash, checks, and credit cards.

AFTER HOURS

If your child has a **medical issue** that cannot wait until Pediatric Associates opens, you may call Pediatric Associates at 940-696-1600 and speak to one of our pediatric providers on call. This service is not to be used for medication refills, appointment scheduling, or billing issues.

PRESCRIPTIONS

Unplanned refills require a **minimum** of 48 hours for completion. A follow-up visit will be scheduled regularly for maintenance medications. There are several ways our patients can be assisted with prescription costs. Please ask your provider or the pharmacy about these services. Controlled substances are not stocked onsite.

FUTURE VISITS – IT IS IMPORTANT TO KEEP YOUR APPOINTMENTS

Remember to bring your medications to every visit. Should your work situation, insurance coverage, or address change, it is your responsibility to make us aware of those changes. **When you know you cannot keep your child's appointment, please make every attempt to cancel the day before. This will allow us to help another patient.**

Patient's Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Parent/Guardian Name: _____ Date of Birth: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Alternate #: _____ Email Address: _____

Employer: _____ Work #: _____

Emergency Contact: _____

Relationship to patient: _____ Phone #: _____

Insurance Company: _____ Policy Holder: _____

Policy Holder's DOB: _____ ID #: _____ Group #: _____

To meet requirements for our funding sources, we need the following information on each patient. Thank you for your assistance!

What is your race? (Check the box that applies)	**What is your ethnicity? (Check the box that applies)**
☐ Asian ☐ African American ☐ American Indian ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ More than one race ☐ Unreported _____ (staff initial)	☐ Latino ☐ Non-Latino ☐ Not reported _____ (Staff initial)
Are you a US Veteran? ☐ Yes ☐ No **Are you a farm worker?** ☐ Yes ☐ No If yes: ☐ Migrant or ☐ Seasonal	**Do you live in public housing?** ☐ Yes ☐ No **Are you homeless?** ☐ Yes ☐ No If yes, please check the correct description: ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street
What is your sexual orientation/gender identity? Please check the box that applies. Patients 0-17 years are not required to complete these fields.	
Sexual Orientation:	**Gender Identity:**
☐ Straight ☐ Gay ☐ Lesbian ☐ Bi-Sexual ☐ Other ☐ Unknown ☐ Decline to Answer _____ (staff initial)	☐ Male ☐ Female ☐ Transgender Male (FTM) ☐ Transgender Female (MTF) ☐ Unknown ☐ Neither exclusively male or female ☐ Other ☐ Decline to Answer _____ (staff initial)

Notice of Privacy Practices:

☐ I have received the Community Healthcare Center's Notice of Privacy Practices.

Rights and Responsibilities:

☐ I have received Community Healthcare Center's Notice of Rights and Responsibilities.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Date

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SIGNATURE ON FILE

I request that payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf to Community Healthcare Center, for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that; payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplies agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature: _____ Date: _____

Medicare #: _____

Medicaid #: _____

Insurance Company: _____ Policy #: _____

NOTICE CONCERNING COMPLAINTS: Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reports for investigation at the following address: Texas State Board of Medical Examiners, Attention: Investigations, 1812 Center Creek Drive, Suite 300. P.O. Box 149134, Austin, Texas 78714-9134

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

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GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better information about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: Community Healthcare Center, (Hereinafter called the "Center") encourages individuals to seek a personal primary care provider for periodic health examinations and for treatment of health problems. The Center services are targeted primarily toward prevention of health problems among those who cannot access a primary care provider. The Center cannot assume the responsibility for payment of medical care received or performed outside the Center, including the delivery of babies, reference lab and/or other diagnostics, etc., even if such care was ordered by Center providers, unless previous authorization has been given by Center's Administration.

DISCLAIMER: Among its services, the Center utilizes screening tests, including certain blood tests, which are a method of identifying individuals who are at risk for developing several common medical problems. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the Center, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form.

INFORMED UNDERSTANDING: I understand that no warranty or guarantee has been made to me as to the result of cure from care and treatment provided.

RELEASE OF INFORMATION: I further understand that all Medical and Social Service Records may be released to representative of the United States Department of Health and Human Services and to representatives of programs or projects funded by this Department and other funding sources for the purposes of determining contract compliance with Federal/State law and regulations. Community Healthcare Center utilizes the MED-IT system for Breast and Cervical Cancer Services (BCCS), and IMMTRAC for immunizations.

CONTRACT PHARMACIES: I understand that Community Healthcare Center provides services through contract pharmacies and/or other venders and my personal health information may be shared with these pharmacies and/or other venders so that I can receive improved access to affordable medications and/or healthcare.

TEACHING FACILITY: I understand and acknowledge that Community Healthcare Center is a teaching center, and my care, and/or the care of patient(s) I am a guardian for, may be provided by a clinician, including but not limited to medical subtends and/or resident physicians and/or resident dentists, in a clinical training program. I further understand and acknowledge that teaching services such as direct observation by other physician and medical students, case discussions, or photographic or video images of care activities involving myself or my dependents are allowed for teaching.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in, and that any questions I have had about the service have been answered to my satisfaction. I further certify that I have read or had read to me* the *Client and Center Rights and Responsibilities* and accept that document.

SIGNATURES: Fill blank lines with NA if not applicable.

SECTION I:

Patient's Name _____ Signature _____

Person Authorized to Consent (if not patient) _____ Relationship _____

Signature _____ Date _____

SECTION II:

Counselor Name: _____ Signature: _____

Date _____

*Translated into _____/ Read to me by _____

Signature of Person translating or reading consent to patient:

_____

Date: _____

Client #: _____

Pediatric Associates

PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES

Welcome to the center. 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 ask us questions you might have.

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 in accordance with applicable federal, state and local laws or regulations.

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 needs 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 prohibits the center from denying you primary health care services which are medically necessary solely because you cannot pay for these services.

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").

Health Care:

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.
4. You are responsible for appropriate use of center services, which includes following staff instructions, making and keeping scheduled appointments, and requesting a "same day" 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 of your pain, in a manner that tis consistent with your age, condition, and ability to understand. We are not a pain management clinic. You have a right to be informed of treatment options for pain management, allowing you to make an informed decision regarding your treatment plan.

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 jeopardizing your status as a patient at the Center.
4. You have a responsibility to treat center staff and providers with respect and dignity, regardless of race, color, marital status, religion, gender, sexual orientation, national origin, ancestry, physical or mental handicap or disability, age, veteran status, or political affiliation, or other grounds, in accordance with applicable federal, state, and local laws or regulations.

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.

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);

This Center maintains ZERO TOLERANCE of abuse, harassment, violence, or any other criminal behavior. A person who commits, causes or threatens to cause abuse, harassment, violence, or criminal behavior of any kind is subject to immediate termination as a patient of the Center and/or removal from the Center premises.

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.

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PA Sliding Fee Application

_____ _____
Last Name First Name

_____ _____
Date of Birth Phone Number

Are you employed? ☐ Yes ☐ No _____
Name of Employer

Do you receive: ☐ Social Security ☐ Unemployment?

Please list spouse and dependents living in your household:

Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____
Name _____ DOB_____ Relationship _____

By my signature below I attest that the information provided herein is complete and accurate. I understand that I may be required to provide additional information and documentation upon request for the purpose of determining my eligibility to participate in the Sliding Fee Discount Program. I agree to inform CHC of any changes of condition or circumstance that might impact my eligibility to participate in the Discount Program. I understand I am responsible for a minimum of at least $30 at the time of each medical visit unless other arrangements have been made.

_____ _____
Patient/Guardian Signature Date

Office Use only

Household Income: $_____ Family Size: _____ Percentage of Discount: _____%

Type of Income: ☐ Check Stub ☐ W2 ☐ Award Letter ☐ Other: _____

PM System Updated: ☐ YES ☐ NO Expiration Date: _____

_____ _____
Staff Signature Date

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Please circle the range of annual household income for your family size.

Family Size	Range of Annual Household Income			
1	$12,490 or less	$12,491 - $18,859	$18,860 - $24,980	More than $24,980
2	$16,910 or less	$16,911 - $25,532	$25,533 - $33,820	More than $33,820
3	$21,330 or less	$21,331 - $32,206	$32,207 - $42,660	More than $42,660
4	$25,750 or less	$25,751 - $38,380	$38,881 - $51,500	More than $51,500
5	$30,170 or less	$30,170 - $45,554	$45,555 - $60,340	More than $60,340
6	$34,590 or less	$34,591 - $52,227	$52,228 - $69,180	More than $69,180
7	$39,010 or less	$39,011 - $58,901	$58,902 - $78,020	More than $78,020
8	$43,430 or less	$43,431 - $65,575	$65,576 - $86,860	More than $86,860
9	$47,850 or less	$47,851 - $72,249	$72,250 - $95,700	More than $95,700
10	$52,270 or less	$52,271 - $78,922	$78,923 - $104,540	More than $104,540

_____ _____

Patient/Guardian Signature Date

Chart # _____

Revised 5/2019

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HIPAA RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Please list anyone you give us permission to speak with regarding your protected health information. This information may include: diagnosis, test results, recent visits, medication requests, appointment information, and billing/insurance information.

I authorize the release of my personal health information to the following:

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB _____

This authorization will remain in effect until revoked by me in writing.

_____ _____

Signature Date

_____ _____

Witness Date

This does not authorize copies of protected health information to be released, mailed, or faxed to the person(s) listed. To obtain paper copies of protected health information, a valid HIPAA release is required.

Effective January 30, 2018

Chart # _____

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CONSENT TO TREAT A CHILD

Child's Name: _____ Date of Birth: _____ Chart #: _____

I, _____, _____ as parent/legal guardian of the
PRINTED NAME RELATIONSHIP TO CHILD

above named child, give my permission to the following persons listed below to bring the above named child to Community Healthcare Center (and any of its service locations) for treatment **and** to consent to all immunizations, injections, or other medical therapies and procedures as they seem appropriate.

PRINTED NAME	DATE OF BIRTH	RELATIONSHIP TO THE CHILD

If there is any change in the above list, I will inform the clinic in writing immediately.

_____ _____ _____
Signature Date Telephone Number

_____ _____ _____
Witness Signature Date Witness Printed Name