Acacia Medical Mission

NEW PATIENT REQUIREMENTS

Resides with in Comal County, does not have any other health insurance and meets 200% poverty level

1. **With the application please provide:**

    - Proof of Income: One of the following:
      Income tax return
      W2
      Last 3 paychecks
    - Photo ID
    - Bill showing proof of Residency

2. **Patient intake health history appointment**

3. **Provider appointment**
    - Bring all current medications to every appointment
    - $20 Suggested donation

Application for Assistance

Acacia Medical Mission

Date: _____

Applicant's Name_____ **Age**_____ **DOB**_____
Social Security #_____ ID_____
Address:_____ **City**_____ **State, Zip**_____
Phone: (Hm)_____ **(Cell)**_____ **Work**_____
Email: _____

Are you a resident of: Comal____ **Blanco**____ **Other** ____ **Are you a US Citizen? Yes**____ **No**____

_____**Married** _____**Separated** **Preferred Language: English / Spanish**
_____**Divorced** _____**Widowed** **Caucasion** _____ **Hispanic** _____
_____**Roommate** _____**Single** **Other**_____

Emergency Contact Information:

Name_____ **Relationship**_____
Address:_____
Phone_____

Name_____ **Relationship**_____
Address:_____
Phone_____

Do you work? Yes_____ **No**_____
Applicant's Occupation_____
Employer_____

Total # of People in Household_____

Total Income **$**_____

Do you have insurance?_____ **(includes Medicare, Medicaid, Work Comp, VA Benefit)**

_____
_____

Agreement between Clinic and Patients

The Clinic was established to provide medical care to the following people:

- Those who do not have medical insurance or the funds to pay for private medical care
- Those who do not qualify for Medicare, Medicad or other assistance programs nor the funds necessary to pay for private care.

THE CLINIC AGREES TO PROVIDE AT NO COST:

- Physical exams and medical care by volunteer healthcare Providers
- Medications as available

THE PATIENTS ARE EXPECTED TO:

- Cooperate with their health care Provider. This comes in the form of:
  - Courteous behavior
  - Health maintenance
  - Appearance
- Purchase medications when not available through the Clinic or Any Baby Can
- Assume financial responsibility for referrals to other Doctors made by the Clinic
- Assume financial responsibility for labs and x-rays if you have insurance with a high deductible, or are getting labs for a specialist
- Donate $20.00

I have read and understand the above information and agree to its contents:

_____

Patient Signature

_____

Witness Signature

Date: _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patient), and may have disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____**Signature**_____**Date**_____

COMPLIANCE ASSURANCE NOTIFICATIONS FOR OUR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHO) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standard of ethic and integrity in performing services for our patients.

It is our policy to properly determine appropriate users of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not Perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Acknowledgement of Review of Notice of Privacy Practices

Acacia Medical Mission

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I have been advised that Acacia Medical Mission will keep my medical information confidential and that it will only be shared between health care providers involved in my care.

In addition, I give permission for Acacia Medical Mission to share my medical information with the following individuals: (Please sign your name and indicate below anyone who has permission to access your information).

Individual(s) with authorization to receive my medical information: (Please include yourself)

1._____

2._____

3._____

4._____

Patients Printed Name: _____

Patients Signature: _____Date_____

Consent to Treatment by Volunteer Medical Professionals

I understand that services I receive from Acacia Medical Mission may be provided by volunteer medical professionals that are providing care that is not administered for or in expectation of compensation.

I further understand that state and federal law imposes a limitation on the recovery of damages from such a volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

1. The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization;
2. The volunteer commits the act or omission in the course of providing health care services to the patient;
3. The services provided are within the scope of the license of the volunteer; and before the volunteer provides health care services, the patient (or if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient) signs a written statement that acknowledges;
    a. That the volunteer is providing care that is not administered for or in expectation of compensation; and
    b. The limitations on the recovery of damages from the volunteer in exchange for receiving the health care services and that limitation is $5.00.

I have read and understand the above and choose to be treated by a volunteer medical professional, understanding the limitations on the recovery of damages described above for:

( )Myself

( )The following person for whom I am legally responsible:_____

Print Patient Name

_____ _____

Print Name **Signature**

_____

Date

ACACIA MEDICAL MISSION PATIENT AUTHORIZATION

Please read, initial and sign below:

(Initial)_____**Privacy Policy**: I acknowledge that I received, reviewed and agree to comply with the Acacia Medical Mission Privacy Policy.

(Initial)_____**Consent to Treat**: I have the legal right to consent to medical and surgical treatment for myself. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of Acacia Medical Mission believe are necessary for me. I understand that by signing this form, I am giving permission to the doctors, nurses and other healthcare providers to provide treatment for me as long as I am a patient at Acacia Medical Mission.

(Initial)_____**E-Prescribing**: I voluntarily authorize Acacia Medical Mission to allow E-Prescribing for my prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history so long as I am a patient at Acacia Medical Mission. My preferred pharmacy is _____ located at _____.

(Initial)_____**Recording/Photo Policy**: Acacia Medical Mission does not permit recording devices in the exam room or common areas. Our staff and other patients have the right to their image and likeness; therefore, we do not allow recording or photos of any kind during the visit. I understand the policy and agree to comply.

(Initial)_____**Phone Messages**: I give my permission for Acacia Medical Mission to leave detailed phone messages when I am unable to answer my phone.

(Initial)_____I understand I can withdraw my consent at any time by contacting Acacia Medical Mission in writing at 1781 E. Ammann Rd, Bulverde, TX 78163

Name:_____

DOB:_____