# Welcome to Carevide

## Carevide Locations

### Family Medicine

**Carevide** Bonham
920 N Center St
Bonham, Texas 75418
903.583.6155

**Carevide** Cooper
91 W Side Square
Cooper, Texas 75432
903.395.0586

**Carevide** Farmersville
111 N Johnson St
Farmersville, Texas 75442
972.782.6131

**Carevide** Greenville
4311 Wesley St
Greenville, Texas 75401
903.455.5958

**Carevide** Kaufman
101 N Houston St
Kaufman, Texas 75142
972.932.7001

### Dental

**Carevide Dental**
3600 Caddo St
Greenville, Texas 75401
903.454.6965

### Pediatrics

**Carevide Pediatrics**
3005 Joe Ramsey Blvd E, Suite A
Greenville, Texas 75401
903.455.4458

### Women's Health

**Carevide Women's Center**
4311 Wesley St, Suite B
Greenville, Texas 75401
903.455.5010

## What to Bring to Your Appointment

### Please bring the following along with your completed patient packet:

The following will be needed for all household members (if applicable):

- ☐ **Photo Identification** (Driver's License, School, Military, Identification Card, etc.)
- ☐ **Proof of Insurance** (Insurance Card); if applicable
- ☐ **Current medications**

### Sliding Fee Discount Requirements:

For all uninsured patients or patients with private insurance that qualify for our sliding fee discount for charges applied to the deductible or non-covered charges, the follow is required:

- ☐ **Three (3) Proof of Income statements for all household members dated within the last 60 days.**
- ☐ **Household members include** spouse, common-law spouse, or live-in boyfriend/girlfriend.
- ☐ **Proof of income may include** check stubs dated within the last 60 days, letter from employer on letterhead, social security award letter, most current tax return (required if you are a business owner), child support, unemployment, and/or a letter of support accompanied with a copy of the supporter's ID and contact information.

**APPOINTMENT DATE:** ____________________________

**APPOINTMENT TIME:** ____________________________

Thank you for choosing Carevide for your health care needs. We know you have a choice in your healthcare provider, but in choosing us, please know that we are committed to being available for you, knowing you and your health history, helping you understand your care and assisting you to coordinate your health care. Carevide offers a range of care including family practice, pediatric care, women's health services, behavioral health and dental services.

As a recognized Patient Centered Medical Home, we are focusing on strengthening the relationship between the patient and the provider by replacing short-term episodic care with long-term relationships and whole-person care. Within a Patient Centered Medical Home, patients are active participants in their care and the primary care provider serves as the "home", where patients go for the majority of their care.

As your Medical Home we will:

- Learn about you, your family, life situation, and health goals
- Coordinate your care with specialists as your health needs change
- Be available to you after hours for your urgent needs, through our on call physicians, which may be accessed by calling the office phone number at any time; during or after office hours
- Communicate clearly with you so you understand your condition(s) and all of your options
- Listen to your questions and feelings
- Help you make the best decisions for your care
- Offer health education
- Provide evidence-based care by integrating clinical expertise with current best practice recommendations, by planning your care according to need and using point-of care reminders based on current guidelines
- Support for self-management
- Provide assistance in obtaining health records from current and/or previous providers

We also encourage you as the patient to be in charge of your own health by participating in your care and communicating openly with your care team.

We trust you, as our patient, to:

- Know that you are a full partner with us in your care
- Provide a complete medical history to your care team
- Come to each visit with any updates on medications, dietary supplements, or remedies you  are using, and questions you may have
- Let us know when you see other health care providers or have a visit to the Emergency Room so we can help coordinate the best care for you
- Keep scheduled appointments or call to reschedule or cancel as early as possible
- Understand your health condition(s): ask questions about your care and tell us when you don't understand something
- Contact us after hours if your issue cannot wait until the next work day
- Give us your feedback to help us improve our care for you

Carevide now offers access to a Patient Portal where you, the patient, may contact the center's staff members through direct messaging with any questions, request appointments, check diagnostic and lab test results, view your medication list as well as request your prescription refills.

We thank you again for choosing us as your provider of choice.

Sincerely,
Carevide

# Registration Form

PLEASE PRINT

**Today's Date:** / /

| Primary Care Provider (PCP): *or check if establishing today* ☐ | Primary Dental Provider: *or check if needed* ☐ | If Applicable, Women's Health Provider: |
|---|---|---|

## PATIENT INFORMATION

| Patient's Last Name: | First Name: | Middle Name: | Age: | Date of Birth: / / | Sex at Birth: ☐ M ☐ F |
|---|---|---|---|---|---|

Is this the Patient's Legal Name? ☐ Yes ☐ No If No, What is Patient's Legal/Former Name:

| Street Address: | City / State / Zip: | P.O. Box: |
|---|---|---|
| Patient Social Security #: | Primary Language Spoken: | If Applicable, Patient Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow |
| Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown | Race: ☐ White ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Native Hawaiian ☐ American Indian/Alaskan Native ☐ Unreported/Refused | Patient Served in Military? ☐ No ☐ Yes |

| Parent/Guardian Full Name (if applicable): | Parent/Guardian Date of Birth: / / | |
|---|---|---|
| Relationship to Patient: | Is Parent/Guardian a patient of Carevide? ☐ Yes ☐ No | |
| Employer/Occupation: | Employer Phone #: | Need a Translator? ☐ Yes ☐ No If Yes, Language: |

| Day Phone: | Alternate #: | Email: | Contact Preference: ☐ Day Phone ☐ Alternate ☐ Email ☐ No Contact |
|---|---|---|---|

How did you hear about us? ☐ Friend ☐ Family ☐ Staff ☐ Internet Search ☐ Facebook ☐ Ad ☐ Insurance ☐ Event ☐ Other:

| Homeless? ☐ Yes ☐ No If Yes, need help? | Live in Public Housing? ☐ Yes ☐ No If Yes: ☐ High Rise ☐ Low Rise ☐ Section 8 ☐ Other ___________ | Migratory / Seasonal Agricultural Worker? ☐ Yes ☐ No |
|---|---|---|

We are here to help in ways you may not realize. We're able to provide resources such as our sliding fee discount. Our sliding fee discount is based on family size and income and helps you if something applies to deductibles, is non-covered, or if insurance is lost. To plan for the future of these resources, we're required to gather the numbers below. Your personal information is not shared and is kept here. **Please complete as best you can**:

Number of Immediate Family in Household: _____ Household Income: $__________ ☐ Monthly ☐ Yearly

**Please select one below**:

☐ I've completed the above and do not want to see if we're discount eligible; I'll sign a waiver. Should anything change, I'll inform you. Thank you!

☐ I've completed the above and if potentially eligible, please let me know. If we far exceed the range, I know it's available and will sign the waiver. If potentially eligible, I'll bring proof of income by my second visit and will let the scheduler know so there's enough time for the process. Thank you!

## INSURANCE INFORMATION PLEASE GIVE INSURANCE CARD TO THE RECEPTIONIST.

| Primary Insurance: Subscriber Name: Subscriber ID #: Group #: | Subscriber Address (if different): | Sub. Daytime #: Sub. Date of Birth: / / |
|---|---|---|
| | Patient's Relationship to Subscriber: Is Subscriber a Patient Here? ☐ Yes ☐ No | Sub. Social Security #: |
| Secondary Insurance: Subscriber Name: Subscriber ID #: Group #: | Subscriber Address (if different.): | Sub. Daytime #: Sub. Date of Birth: / / |
| | Patient's Relationship to Subscriber: Is Subscriber a Patient Here? ☐ Yes ☐ No | Sub. Social Security #: |

## IN CASE OF EMERGENCY

| Local Emergency Contact or Primary Caregiver: | Daytime #: Alternate #: | Authorized to Release Information? ☐ Yes ☐ No | Relationship to Patient: | Does Patient Have Advanced Directive or Living Will? ☐ Yes ☐ No |
|---|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carevide or the insurance company to release any information required to process my claims.

Patient/Parent/Guardian Signature: Today's Date: / /

# Patient Acknowledgement

| ____________ | ______________________________ | ________________ |
|---|---|---|
| Today's Date | Print Patient's Name | Patient's Birth Date |

**Acknowledgement of Review of 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. I hereby acknowledge that I have been offered and reviewed a copy of Carevide's Notice of Privacy Practices. Effective Date: April 14, 2003; updated with HIPAA Omnibus Rule: September 23, 2013. Initials: ____________

**Acknowledgement of Review of Patient's Rights and Responsibilities**

This notice describes the patient responsibilities to Carevide. I hereby acknowledge that I have been offered and reviewed a copy of Carevide's Patient's Rights and Responsibilities. I agree to all the conditions at Carevide as described in the Patient's Rights and Responsibilities. If I have further questions regarding the Patient Rights and Responsibilities, I may direct questions to the center staff. Initials: ____________

**Consent for Treatment**

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 center's 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). A person who signs a general consent for the performance of medical tests or procedures is not required to also sign or be presented with a specific consent form relating to medical test or procedures to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS that will be performed on the person during the time in which the general consent form is in effect. I understand that I will be asked to sign a separate informed general consent for vaccines administered to me and that I will be asked to sign a separate informed consent for the influenza (Flu) vaccine. I understand that there is a separate consent form that I may be asked to sign for procedures performed in the office. 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. Initials: ____________

**Co-Pay Policy**

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. **IF** proof of income is provided, you may qualify to use our sliding fee scale for services that are not covered by your insurance or for charges that are applied to your deductible. This does not apply to charges that require a copay or co-insurance payment. Thank you for your cooperation in this matter. Initials: ____________

**Cancellation / No Show Policy**

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. If you no show for three (3) consecutive appointments in a year, you may be discharged from care. The health center will notify you in writing, via certified mail, if you are discharged from care. Initials: ____________

**Self-Pay**

I will be responsible for services rendered at Carevide I agree to pay the full and entire amount for treatment given to me or to the above named patient. I also understand that I will be considered as a "full-pay" patient if proof of income is not provided by my second visit for the sliding fee scale. Initials: ____________

# Authorization to Release Information

Today's Date ____________ Print Patient's Name ____________ Patient's Birth Date ____________

## Authorization to Release Information

I hereby authorize any Carevide staff or provider to engage in any verbal or written communication to the person(s) listed below regarding my medical history, medical records, appointments and/or information pertaining to my account and/or billing history with Carevide. I authorize Carevide staff and/or provider to leave health information on a voicemail and/or answering machine at the number(s) listed below. I further authorize Carevide, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

**Initials:** _________

## Person(s) Allowed to Receive Personal Health Information Regarding Patient Care

Contact Name: ____________ Phone Number: ____________

Relationship to Patient: ____________ Date Added: ____________

Ok to Leave Message: ☐ Yes ☐ No Ok to Call/Confirm Appt if contact number(s) on file becomes invalid: ☐ Yes ☐ No

Contact Name: ____________ Phone Number: ____________

Relationship to Patient: ____________ Date Added: ____________

Ok to Leave Message: ☐ Yes ☐ No Ok to Call/Confirm Appt if contact number(s) on file becomes invalid: ☐ Yes ☐ No

Contact Name: ____________ Phone Number: ____________

Relationship to Patient: ____________ Date Added: ____________

Ok to Leave Message: ☐ Yes ☐ No Ok to Call/Confirm Appt if contact number(s) on file becomes invalid: ☐ Yes ☐ No

## Confirmation of Authorization to Release Information

I have read and understand the above information, and I agree to the terms described. I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient, I certify that I am authorized by law to agree to these conditions of treatment on behalf of the patient.

____________ Patient/Parent/Guardian Signature ____________ Date

____________ *Guarantor Signature (If guarantor is not the patient or parent)* ____________ *Print Guarantor Name*

# Authorization for Use and Disclosure of Health Information

Completion of this document authorizes the use and/or disclosure of the patient's Personal Health Information ("Health Information" or "PHI"), as set forth below, consistent with state and federal laws and regulations concerning the privacy of such Information.

Patient Name: ___________________________________________ Date of Birth: ______________________________

Use and Disclosure of Health Information defined In 45 C.F.R. § 164.5011 hereby authorize Carevide and center staff to disclose (release) my Personal Health Information (PHI) as noted below:

From: _______________________________________ To: _______________________________________

Address: _______________________________________ _______________________________________

_______________________________________ _______________________________________

Phone: _______________________________________ _______________________________________

Fax: _______________________________________ _______________________________________

Complete the following by indicating those items that you want disclosed. If all health info is to be released please check all of the above.

- ☐ History and Physical
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ All of the Above
- ☐ Lab Results
- ☐ Patient Allergies
- ☐ Diagnostic Tests
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Other: ______________________

I specifically authorize the disclosure or release of the following information. Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)* _____ Genetic Information (including genetic test results)

_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

I understand that my health Information is being used or disclosed for the following purpose(s):

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ School
- ☐ Employment
- ☐ Legal Purposes
- ☐ Disability Determination

Dates of Treatment: ____________________

This Authorization will expire one (1) year from the date of the signature. Specific Date: _______________

**Notice of Patient's Rights and Other Information**

I understand that I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health Information whose use or disclosure I am hereby authorizing. I acknowledge that Information disclosed pursuant to this authorization may no longer be protected by applicable laws, and could be re-disclosed by the recipient. I understand that have a right to receive a copy of this authorization. I may revoke this authorization at any time, but I must do so in writing and submit it the address below. I understand that my revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. Carevide Privacy Officer P.O. Box 1908, Greenville, Texas 75403.

**Signature**

I have read this release, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the release freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

_________________________________ Print Name

_______________________________________________ Signature of Patient or Personal Representative/Guardian

_______________ Date

_______________ Date Requested

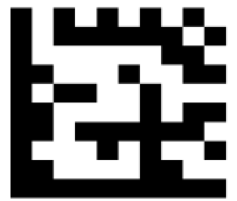
_______________________________________ Requested By

__________________ Date Records Received

Method: Pick-up / Mail / Fax

*If mental health Information is requested to be disclosed to a third party by the patient, the physician or other provider who is in charge of the patient must approve the disclosure (release), if the disclosure is not approved by the physician/provider, the reasons must be documented in the patient's medical record.

TO THE PARTY RECEIVING THIS INFORMATION: This Information has been disclosed to you from records whose confidentiality may be protected under federal law. If so, federal regulations (42 CFR, part 11) prohibits you from making any further disclosures of it without specific written consent of the person so whom it pertains, or as otherwise permitted by regulations.



# *IMMUNIZATION REGISTRY (ImmTrac2)*
## Minor Consent Form

(Please print clearly)

**Child's Last Name**

**Child's First Name** | **Child's Middle Name**

**Child's Date of Birth** ___/___/___ *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

**Child's Address** | **Apartment #** | **Telephone**

**City** | **State** | **Zip Code** | **County**

**Mother's First Name** | **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

**The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.**

### Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

**By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.**
**Parent, legal guardian, or managing conservator:**

Printed Name ______________________

Date ______________ Signature ______________________

**Privacy Notification:** With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

**Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.**

**Questions?** (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

**Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347**

**PROVIDERS REGISTERED WITH ImmTrac2**: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**