NEW PATIENT WELCOME PACKET

Hope Family Care Center (HFCC) is a local medical facility providing quality, personal health care. All patients are welcome and we accept Medicaid, Medicare, and commercial insurance. Uninsured and underinsured patients are charged a small fee using a Sliding Fee Scale based on household income.

HFCC offers complete primary and preventive medical care services for the entire family. All ages are served from newborn babies to the elderly. Our services include Adult and Pediatric Primary Care, Chronic Disease Management, Women's Health and Prenatal Care, Urgent Care, Onsite Laboratory services, Minor Procedures and Specialist Referrals.

Thank you for choosing HFCC for your healthcare needs. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws. To help us meet your needs, please complete this form in ink. If you have any questions or need assistance, please ask registration personnel receptionist or call (816) 861-6500. More information can be found on our website at hfcckc.org.

Please return finished packet to Patient Reception Personnel.

HFCC Mission
To honor God by providing quality, personal health care

HFCC Vision
We envision the day when all residents of our east side community receive high quality and preventive personal health care, regardless of one's income, which has contributed to the overall transformation and well-being of the community

Hope Family Care Center. 816-861-6500. Fax: 816-861-6503. hfcckc.org
3027 Prospect Ave. Kansas City, MO 64128

PATIENT REGISTRATION FORM

Today's date:_____

PATIENT NAME _____**PARENT/GUARDIAN** (if applicable)_____

MALE or **FEMALE** **DATE of BIRTH** ____/____/_____ **SOCIAL SECURITY #** _____-___-_____

ADDRESS_____**CITY** _____ **ST**_____**ZIP** _____

HOME PHONE _____**MOBILE PHONE** _____**EMAIL ADDRESS** _____

MARITAL STATUS (circle one): Single; Married; Divorced; Separated; Widowed

RACE (circle all that apply): Asian; Black/African American; Hispanic; White/Caucasian;
American Indian/Alaskan; Native Hawaiian/Pacific Islander; Other_____

ETHNICITY (circle one): Hispanic or Latino; Not Hispanic or Latino

PREFERRED LANGUAGE (circle one): English; Spanish; Other_____

HOW DID YOU HEAR ABOUT HFCC? (circle one): Family/Friend; Insurance Company; Online; Flyer;
Hospital/Dr. Office; *Walk-in;* Other_____

INSURANCE & BILLING

- ☐ **SELF PAY**
- ☐ **INSURANCE** (Primary)_____ (Secondary)_____
  (include insurance name & ID #)

EMERGENCY CONTACTS

1) NAME _____ RELATION _____PHONE _____
2) NAME _____RELATION _____PHONE _____

PREFERRED FORM OF COMMUNICATION (circle one): Text Email Phone Call

_____ **(Patient Initials)** I give HFCC permission to leave specific medical information on my voicemail or on my answering machine.

_____ **(Patient Initials)** I have reviewed the above information and to the best of my knowledge it is correct and complete.

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FINANCIAL ASSISTANCE APPLICATION

Name of Applicant:_____ Phone number: _____

Address: _____ City, State, and Zip: _____

Household Information: List everyone living in your home, starting with yourself (including unborn children).

Name	Date of Birth	Social Security #	Relationship to you
1.			SELF
2.			
3.			
4.			
5			
6			
7.			
8.			
9.			
10.			

Household Income Information: Please list everyone in the household receiving income. (*Household income includes all income generated by the household, regardless of marital status. Income includes, but is not limited to: salaries, pensions, social security payments, disability payments, alimony, child support, unemployment, self-employment wages, tips, VA benefits, food stamps, TANF, etc. The discount is calculated on total income before taxes.)* *****PLEASE ATTACH PROOF OF INCOME.**

Name of person working or receiving income	Type of Income (employment, SSI, benefits, etc.)	Employer name and phone number	Weekly / Bi-weekly / Monthly / Annual amount received before taxes/deductions
			$
			$
			$

I understand that any insurance payments received by me or on my behalf must be applied to my account before I receive any discounts. I agree to pay at the time of service. I certify the above information is correct and assume the responsibility of contacting HFCC should any changes to my financial or insurance status occur.

_____ _____

Patient's Signature Date

HFCC Staff Initial and Review Date: _____

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3027 Prospect Ave. Kansas City, MO 64128

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. *This section explains your rights and some of our responsibilities to help you.*

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the HFCC Executive Director & Privacy Officer, Nathan Jackson, at nathanj@hfcckc.org or at the phone numbers and addresses at the bottom of each page of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. *If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.*

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site: www.hfcckc.org.

Effective Date: November 24, 2014

Patient HIPAA Acknowledgment, Financial Agreement and Consent Form

Patient Name: _____ Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices:** I acknowledge that I have been offered a copy of the Notice of Privacy Practices, which describes the ways in which Hope Family Care Center may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices. I understand a copy of this document is posted on the practice's website.

_____ (Patient initials) **Financial Agreement**: I hereby assign to HFCC, any and all benefits payable from any policy of insurance covering the patient or person responsible for the patient's care (including but not limited to Medicare, Medicaid, commercial insurance policies, etc.) to be paid directly to HFCC to be applied to the charges for services rendered. I understand I am responsible for co-insurance payments, deductibles and/or any remaining balance. In the event pre-certification for such treatment is required by any health plan or insurance policy, the patient or agent is responsible for obtaining such pre-certification

_____ (Patient initials) **Medicare Non-Covered Service**: I understand that Medicare does not pay for some services that I am fully responsible for payment of this service.

_____ (Patient initials) **Release of Information:** HFCC may disclose all or any part of the patient's medical record to any person or corporation which is or may be liable under a contract for all or part of HFCC's, charges, including but not limited to hospital or medical services companies, insurance companies, pharmaceutical manufacturers, worker's compensation carriers, welfare agencies or patient's employers.

- **Medicare/Medicaid**: The patient or agent affirms that the information provided in applying for payment under Social Security Act Title XVIII (Medicare), State Medicaid laws or any other federal or state Social Security Act Title XVIII program is correct and authorizes HFCC, or its employees or agents to provide medical or other information necessary for processing a claim to any government agency or their intermediaries or insurance carriers. Request is hereby made for payment of authorized benefits on patient's behalf.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below, if I am not available or they are acting on my behalf:

Name	Relationship	Contract Number

Hope Family Care Center. 816-861-6500. Fax: 816-861-6503. hfcckc.org
3027 Prospect Ave. Kansas City, MO 64128

I wish to be treated by ***Hope Family Care Center (HFCC)*** for healthcare services. I understand services are available to me without discrimination prohibited by federal and state law. I understand that health related services may be provided by the employees, agents and independent contractors utilized by HFCC, including but not limited to social work or mental health services.

I understand that *HFCC* is approved to train students. I also understand students may observe or participate in patient care. I permit such involvement, unless I notify HFCC to the contrary in writing, with the understanding that the student's work will be under the supervision of a qualified instructor or staff of HFCC.

While a patient of HFCC, I hereby consent to care and treatment, including but not limited to diagnostics, therapeutic testing and treatment as may be deemed necessary or advisable by my care provider, his/her associates, or designees which may be advisable and necessary based on his/her knowledge and my health condition. I understand that no guarantees have been made to me about the outcome of this care.

With my signature, I certify that I have read the above information or had it read to me, that I am the patient or am authorized to sign for the patient, and that I accept the above conditions for treatment. A copy of this form will be provided to me should I request one.

_____ _____

Name of Patient (Print) **Signature** of Patient (or legal representative)

_____

Date

Office Use Only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign;
- ❑ Communication barriers prohibited obtaining the acknowledgement;
- ❑ An emergent situation prevented from obtaining acknowledgement;
- ❑ Other (please specify).

_____

_____

_____ _____

Name of Employee **Date**

Hope Family Care Center. 816-861-6500. Fax: 816-861-6503. hfcckc.org
3027 Prospect Ave. Kansas City, MO 64128

COMMUNICATIONS CONSENT

Patient Portal Consent

Hope Family Care Center offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:
1) the secure message must reach the correct email address, and
2) only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone. If there is information that you don't want transmitted via online communication, please inform your practice. Patients in our practice may be contacted via email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

_____ **(Patient initials)** I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Text Messaging Consent

Patients in our practice may be contacted via text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information. I understand that this request to receive text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. *There is no charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

_____ **(Patient initials)** I consent to receive text messages at my cell phone and any number forwarded or transferred to that number the communications as stated above.

Patient Name_____ **Patient Signature**_____ **Date**_____

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