COASTAL BEND WELLNESS FOUNDATION
EDUCATION AWARENESS ADVOCACY

2882 Holly Rd., Corpus Christi, Texas 78415 www.cbwellness.org Phone: (361) 814-2001 Fax: (877) 928-8238

PATIENT EXPECTATIONS

CALL TO CANCEL AND RESCHEDULE APPOINTMENTS: If you cannot come to your scheduled appointment, please call **(361) 814-2001** as soon as possible to cancel and reschedule. Not canceling wastes an appointment time that can be used by another patient.

NOT CALLING TO CANCEL APPOINTMENT POLICY: Our policy is that after the 3rd time a patient does not call to cancel an appointment, he or she will not be allowed to make appointments. They may come as a "walk-in" and wait to be seen if the schedule allows.

REMINDER CALL: CBWF calls patients to remind and confirm the patient's appointment date and time. Please be sure we have your correct phone number on file and let us know if you **do not** want us to leave a message on your answering machine.

MEDICATIONS: Please bring your medications to each visit and inform the nurse of any refill needs. Please note that our Medical Providers believe there are multiple ways to address Pain and/or Anxiety, therefore it is the policy of this Health Center not to prescribe Narcotics or other Controlled Substances.

PAYMENT:

- Payment is expected at each visit. CBWF strives to provide quality care at affordable prices and depends on your good faith effort to pay for the services you receive. If you cannot afford our fees, you may apply for a Sliding Fee Scale discount. A payment plan may be arranged if necessary.
- Discounted lab services at CPL and x-ray services at Radiology Associates are offered to qualifying patients.

CONTACT INFORMATION: Please inform the front desk staff of any changes in your phone number, address, or insurance so we can quickly and correctly process your payment and arrange any referrals to specialists.

OTHER SERVICES AVAILABLE

- **Certified Application Counselor (CAC):** Request to see the CAC in our office if you need help selecting an insurance plan available through the ACA Market Place, applying for Medicare/Medicaid or to qualify for our sliding fee discount.
- **Medication Assistance:** Medication assistance is available for eligible patients. Our office staff will assist to obtain free or low cost medications when possible.
- **Mental Health Services:** Our behavioral health department offers counseling, psychiatric services and substance abuse counseling.

X_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

PATIENT NAME (Print) **Account Number #**

COASTAL BEND MEDICAL AND WELLNESS
REGISTRATION FORM

Today's Date:	**Reason for Visit:**

PATIENT INFORMATION

Patient's Last Name:	**First:**	Middle Initial:	**Social Security Number:** / /
Address:	Apartment:	**City, State:**	**Zip Code:**
Date of Birth: / /	**Gender at Birth:** Male ☐ Female ☐	**Home Phone Number:** ( ) -	Cell Phone Number: ( ) -
Email Address:		Preferred Name:	
Marital Status: Single ☐ Married ☐ Divorced ☐ Widow ☐ Domestic Partnership ☐	**Employment:** Unemployed ☐ Part-time ☐ Full-time ☐	Employer:	Employer Phone Number: ( ) -

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Multiracial ☐ Pacific Islander ☐ Hawaiian ☐ Am. Indian/Alaskan Native

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Other_____

Sexual Orientation:
☐ Heterosexual (Straight)
☐ Homosexual (Lesbian or Gay)
☐ Bisexual
☐ Something else

Gender Identity:
☐ Male
☐ Female
☐ Transgender Male / Female → Male
☐ Transgender Female / Male → Female

Preferred Language:
☐ English
☐ Spanish
☐ Other_____

Please check all that apply:
Migrant Farmer ☐ Homeless ☐ Veteran ☐
Seasonal Farmer ☐ Living at Homeless Shelter ☐ Student ☐ School:_____

Service Type: (Please check all that apply.)	Medical Care		Psychiatry		Will You require a sliding scale discount? ☐ Yes ☐ No (Proof of Household Income Required)
	Counseling		Breast Friends		

List any other family members seen here:

INSURANCE INFORMATION (Please present Insurance Card to Front Office)

Plan Name:	**Member ID:**	**Group#:**

Subscriber's Name:	Subscriber's Social Security Number: / /	Subscriber's Birth Date: / /
Subscriber's Address:	Subscriber's Phone Number: ( ) -	

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (Specify): _____

IN CASE OF EMERGENCY

Local friend/relative (not living at your address):	**Relationship to Patient:**	**Home Phone Number:** ( ) -	**Cell Phone:** ( ) -

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to CBWF. I understand that I am financially responsible for any balance. I also authorize CBWF or insurance company to release any information required to process my claims. **I give CBWF permission to leave phone messages concerning my care**:
Yes ☐ **No** ☐

The importance of the legal document, **Advance Directive**, has been explained to me as: a document designed to help me communicate my wishes about medical treatment at some time in the future when I am unable to make my wishes known because of illness or injury. I have been offered an Advance Directive and I willfully: Accept ☐ Decline ☐

Patient Signature: X **Date:**

Household Income and Family Size Survey

The reporting of Household Income and Family size is required by the Health Resources and Services Administration to help better understand the community we serve as well as the need for Safety Net providers such as Community Health Centers and Safety Net Vaccination programs.

Please answer honestly, your income information will never be shared or reported individually.

☐ $ 0 - $5,000	☐$50,000 - $54,999	☐$100,000 - $104,999	☐$150,000 - $154,999
☐ $5,000 - $9,999	☐$55,000 - $59,999	☐$105,000 - $109,999	☐$155,000 - $159,999
☐$10,000 - $14,999	☐$60,000 - $64,999	☐$110,000 - $114,999	☐$160,000 - $164,999
☐$15,000 - $19,999	☐$65,000 - $69,999	☐$115,000 - $119,999	☐$165,000 - $169,999
☐$20,000 - $24,999	☐$70,000 - $74,999	☐$120,000 - $124,999	☐$170,000 - $174,999
☐$25,000 - $29,999	☐$75,000 - $79,999	☐$125,000 - $129,999	☐$175,000 - $179,999
☐$30,000 - $34,999	☐$80,000 - $84,999	☐$130,000 - $134,999	☐$180,000 - $184,999
☐$35,000 - $39,999	☐$85,000 - $89,999	☐$135,000 - $139,999	☐$185,000 - $189,999
☐$40,000 - $44,999	☐$90,000 - $94,999	☐$140,000 - $144,999	☐$190,000 - $194,999
☐$45,000 - $49,999	☐$95,000 - $99,999	☐$145,000 - $149,999	☐$195,000 - $199,999

Number of individuals in your home:_____

When determining the numbers in your household please include the following:

- Spouse/Significant Other/Life Partner
- Dependent Children that can be claimed on your tax return
- Dependent Parents or relatives who can be claimed on your tax return.

Individuals in the household who can file their own tax return should not be included in determining Household size.

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Authorization for Release of Protected Health Information

By signing this form, I authorize Coastal Bend Medical and Wellness to use and disclose my protected health information for treatment, payment or healthcare operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following practice: Coastal Bend Wellness Foundation: Attn: Medical Records: 2882 Holly Road, Corpus Christi, Texas 78415.

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

I have received and reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. This office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice at the office. The practice will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I may refuse to consent to the use or disclosure of my 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).

I authorize Coastal Bend Wellness Foundation to disclose my protected health information to the following personal representatives:

_____

_____

_____

X_____

Patient's Signature

_____

Date

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PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES

Welcome to **Coastal Bend Wellness and Medical.** Our goal is to provide quality health care to qualified persons in this community, regardless of their ability to pay. If we are enrolling new patients, you may be eligible to become our patient. As a patient, you have rights and responsibilities. We have rights and responsibilities also. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read this statement and ask us any questions that you might have.

Human Rights:

1. You have a right to be treated with respect and dignity regardless of race, religion, sex, national origin, sexual orientation, political affiliation or ability to pay for services.

Payment for Services:

2. You are responsible for giving us accurate information about your present financial status and any changes in your financial status. We need this information to decide how much to charge you and/or bill private insurance, Medicaid, Medicare, or other benefits you may be eligible for. If your income is less than the federal poverty guidelines, you will be charged a discounted fee.
3. You have a right to receive explanations of your bill. You must pay, or arrange to pay, all agreed fees for medical services or dental services, as provided by our policies. If you cannot pay right away, please let us know so we can provide care for you now and work out a payment plan.
4. Federal law prohibits us from denying you primary health care services, which are medically necessary, solely because you cannot pay for these services.

Privacy:

5. 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 records, unless you request in writing for us to show them to someone else. A complete discussion of your privacy rights is attached as *"Notice of Center Privacy Practices "*. By signing this document you are indicating that you have received this Notice. The Notice details the various rights granted to you under the Health Insurance Portability and Accountability Act.

Health Care:

6. You are responsible for providing us complete and current information about your health or illness, so that we can give you proper health care. You have a right to, and are encouraged to participate in decisions about your treatment.
7. 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 risks) and expected outcome, if known, and 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 a legally authorized person.
8. You are responsible for appropriate use of our services, which includes following our staffs instructions, making and keeping scheduled appointments, and only requesting a "walk in" appointment when you are ill. We may not be able to see you unless you have an appointment. If you do understand or cannot follow the staff's instructions, please tell us so we can help you.
9. If you are an adult, you have a right to refuse treatment to the extent permitted by law, and to be informed of **the risks of refusing such care. You are responsible for the outcome of refusing treatment.**

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10. You have a right to health care and treatment that is reasonable for your condition and within our capability. You have a right to be transferred or referred to another facility for services that we cannot provide. However, we do not pay for services that you get elsewhere. **Note: Coastal Bend Wellness Foundation is not an emergency facility.**

Center Rules:

11. You have a right to receive information on how to appropriately use our services. You are responsible for using our services in an appropriate manner. If you have questions about using center services, please ask us.
12. You are responsible for the supervision of children you bring with you to our Center. You are responsible for their safety and the protection of other clients and our property.
13. You have a responsibility to keep your scheduled appointment. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments for three (3) consecutive times you will be asked to meet with the Chief Executive Officer or designee staff to determine the reason for your missed appointments and whether you can continue as a patient of **Coastal Bend Wellness Foundation**

Complaints:

14. If you are not satisfied with our services, please tell us. We welcome suggestions, so we can improve our services. We will tell you how to file a complaint. If you are not satisfied with how we handle your complaint, you may file a complaint with the Board of Directors.
15. We will not punish you for filing a complaint and will continue to see you as a patient.

Termination:

16. We can decide to stop treating you as a patient. If we stop treating you as a patient, you have a right to advance notice that explains the reason for the decision, and you will be given 30 days to attempt to find other health services. After notice of termination, we will only provide urgent care for a 30 day period while you find a new provider. WE can decide to stop treating you immediately and without notice, if we have determined that you have created a threat to the safety of the staff and/or other clients. You also have a right to receive a copy of our termination policy. Other reasons for which we may stop seeing you include:
    a. Failure to obey our rules,
    b. Failure to keep scheduled appointments three (3) times,
    c. Intentional failure to report accurate information concerning your health,
    d. Intentional failure to follow the health care program, such as instructions about taking medications, personal health practices, or follow-up appointments, as recommended by your doctor,
    e. Creating a threat to the safety of the staff and/or other clients, and/or loud verbal or physical abuse or harassment of Center staff, and
    f. Intentional failure to report accurately your financial status.
17. If we have given you notice of termination, then you have the right to appeal the decision to the Board of Directors.

X_____ _____

Patient's Signature Date

_____ _____

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Consent to Treatment

Patient Name: _____ Date of Birth: _____ Age:____

Name of Person Giving Consent, if Different From Patient: _____

Relationship to Patient: _____ Self_____Parent _____ Guardian _____ Other: _____

1. I hereby authorize the Physicians, Physician Assistant, Advance Practice Nurse and any other Clinical Staff) on staff at this Health Center, at their service locations, and consent to care encompassing routine diagnostic procedures, examinations and medical treatment and dental treatment, if applicable. This includes, but is not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-ray's, heart tracing, administration of medications, procedures, examinations and treatment prescribed by the medical staff (physicians, mid-level providers), and dental staff if applicable, and counseling services necessary to receive family planning services as defined by federal regulation. I understand that there are no guarantees being made to me concerning the results of my treatment or the effectiveness of any birth control methods.
2. I further understand that a mid-level provider (Physician Assistant, Advance Practice Nurse) is not a licensed physician and may not treat or diagnose any illness, injury, or medical (and dental if applicable) condition except under the supervision and direction of a licensed physician. I further understand that I may revoke this authorization at any time and may request to be seen by a licensed physician or their designated physician replacement.
3. Release of Information: I authorize this Health Center to release medical (and dental information if applicable) information to third party insurance carriers for the purpose of filing insurance claims related to (his/her) medical (and dental care if applicable) care.
4. I further authorize the release of medical (and dental information if applicable) information about my treatment here to my (his/her) doctor or any designated by me.
5. I have read or had read to me the Clients and Center Rights and Responsibilities and accept that document. I certify that this form has been fully explained to me, that I have read it, or have had it read to me, that the blank spaces have been filled in ink, and that I understand its contents.
6. I understand that this consent form will be valid and remain in effect as long as I attend the Health Center. I have been given an opportunity to ask questions about the services to be provided by this center and I believe that I have sufficient information to give this informed consent.

X_____ _____

Patient's Signature Date

If Patient is 17 years or younger or unable to consent complete the following: *The Patient is unable to consent because*

_____

_____ _____

Signature of Person Giving Consent Date Relationship

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Authorization to Release Confidential Health Related Information

I, _____,(DOB:_____)authorize the Coastal Bend Wellness Foundation located at 2882 Holly Rd., Corpus Christi, Texas 78415 to use and disclose the protected health information described below.

☐to ☐from Provider:_____

Address:_____

Phone:_____ Fax:_____

☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV/AIDS, and treatment of alcohol or drug abuse).

☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental Health records
- ☐ Communicable Diseases (including HIV/AIDS)
- ☐ Alcohol/Drug Abuse Treatment
- ☐ Other (Please specify):

This authorization for release of information covers the period of healthcare from:

- ☐ From:_____To: _____
- ☐ all past, present, and future periods.

I understand that the medical information may be used for medical decision making, billing or claims payment, or other purposes as directed. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that an person or entity has already acted in reliance of my authorization or if my authorization was obtained as a condition of obtaining insurance coverage.

Patient's Signature:_____ Date:_____