Scope of Services & Sliding Fee Scale

Sliding Fee Scale: Based upon Federal Poverty Income Level Guideline (FPIL)

	FPIL	Cost per Medical Visit
	0-100%	$25.00
	101-150%	$30.00
	151-200%	$35.00

	FPIL	Cost per Dental Visit
	0-100%	25% of charges
	101-150%	50% of charges
	151-200%	75% of charges

Medical Visit: Includes the examination by a medical provider, limited general health screening lab tests, in-house lab tests and screening mammograms.

Extended Services: Medical procedures and lab tests requiring payment in addition to the visit co-pay. See Prompt Pay Incentive below. Additional information is available at the check-in window.

Prompt pay Incentive: A prompt pay incentive of a 40% reduction from the full price is available when services provided are paid in full at the time of the appointment.

Prenatal/Obstetric Services (available at some locations): Insurance, Medicaid, and CHIP Perinatal are accepted. Patients without insurance can take advantage of our prompt-pay incentive.

Pharmacy/Prescriptions: Located in the Bryan clinic. Prescriptions are provided at cost plus a dispensing fee. The pharmacy accepts Medicaid and CHIP.

Immunizations: Vaccines are provided at cost. Children may qualify for free vaccines.

Behavioral Health Services: A referral from your primary care provider is required. The Sliding Fee cost for mental health services is the same as a Medical Visit.

Medication Assistance Program (MAP): $10.00/pharmaceutical company application. The MAP program provides assistance in obtaining free medication for low-income patients. *Not all medications are available*. The MAP caseworker will provide additional information. A referral from your primary care provider is required.

Transportation Assistance: Where available, we can help you access transportation services in your community in order to help you get to your medical appointments.

Referral Services: We offer assistance with making appointments for your referrals.

After-Hour / Weekend Services: Call the main number of your local HealthPOiNT for the on-call doctor or nurse. The Bryan clinic offers sick visit appointments on Saturdays from 9:00 a.m. to 2:00 p.m. for established patients from any HealthPOiNT site.

Services NOT PROVIDED:

- In-Patient (Hospital) care
- Financial Support for Referrals to Medical Specialists
- Any service or procedure not specifically outlined within the Scope of Service listed above

It is our desire to serve as the medical home for you and your family. All services may not be available at every center. The Scope of Services and the Sliding Fee Scale are subject to change.

Patient Signature:____ Date:_________________________

Effective: 02/11/2013
Revised 02/05/2013
Approved: 01/09/2013

General Consent and Disclosure

The information in this consent form is given so that you will be better informed 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: HealthPOiNT Clinics (hereinafter called "the Clinics") encourage individuals to seek a personal physician for periodic health examinations and for the treatment of medical or behavioral health problems. The Clinics' services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Clinics cannot assume the responsibility for payment of medical or behavioral health care received outside the Clinics, including the delivery of babies, unless previous authorization has been given.

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

GENERAL CONSENT: I give permission to the Clinics, their designated staff, and other medical personnel providing services under their 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. *Behavioral Health treatment of a minor cannot be provided without consent of a legal authorized representative.*

INFORMED CONSENT: In addition to the above general consent, I ☐ **give** / ☐ **DO NOT give** permission to the Clinics, their designated staff, and other medical personnel providing services under their sponsorship to perform the following procedures: medications for tuberculosis and Hansen's Disease, immunizations, injectable medication for sexually transmitted diseases, family planning methods, PKU special counseling, behavioral health, substance abuse treatment, and HIV testing.

INFORMED UNDERSTANDING: I understand that there are certain hazards and risks connected with all forms of treatment, and 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 Records, Behavioral Health/Substance Abuse Records, and Social Service Records may be released to representatives of the United States Department of Health and Human Services and to representatives of programs or projects funded by this Department and other funding services sources for the purposes of determining contract compliance with Federal/State law and regulations.

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 services have been answered to my satisfaction. I further certify that I have read the Patient and Clinic Rights and Responsibilities and accept that document.

EXPIRATION: I understand that this consent is valid and remains in effect as long as I am a patient of HealthPOiNT, until I withdraw my consent, or until HealthPOiNT changes its services and asks me to complete a new consent form.

SIGNATURES: *Fill blank lines with NA if not applicable.*

SECTION I:

Patient Name: ______________________________ DOB: ______________ Sex: ______

Patient Signature: ____

Person Authorized to Consent (if not patient): ______________________ Relationship: ______________

Signature: ______________________________________ Date: ______________

SECTION II:

Staff Member Name: ______________________________

Staff Member Signature: ______________________________ Date ______________

Patient and Center Rights and Responsibilities

Name: ___________________________ Date of Birth: ____/____/____ MR#: ____________

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 read and sign this statement and ask us questions you might have.

A. Human Rights

You have a right to be treated with respect and dignity regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age, Vietnam era veteran status, sexual orientation, political affiliation, or ability to pay for services.

B. Payment For Services

1. 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 so we 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 our 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 us know so we 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.

C. 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 Notice of Client Privacy Rights. The Notice of Client Privacy Rights 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"). By signing this document you are indicating that you have received this Notice.

D. <u>Health Care</u>

1. 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, 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, and your 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.

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 our services, which includes following our staff's instructions, making and keeping scheduled appointments, and requesting a "walk in" appointment only when you are ill. We may not be able to see you unless you have an appointment. If you are unable to follow instructions from the staff, please tell us so we 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. 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 and pain management, as necessary.

E. 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 their 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 asked to meet with the Medical Director or designee to determine the reason for your missed appointments and whether you can continue as a patient of the Center.

F. Complaints

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Our 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, you will not be punish, discriminated or retaliated against for filing a complaint, and the Center will continue to provide you services.

G. 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 "Patient Communication Regarding Noncompliance and Termination" policy and procedure.

Reasons for which we may stop seeing you include:

- Failure to obey center rules and policies, such as keeping scheduled appointments;
- Intentional failure to accurately report your financial status;
- Intentional failure to report accurate information concerning your health or illness;
- 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), and/or
- Creating a threat to the safety of the staff and/or other patients.

H. <u>Appeals</u>

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 of Directors. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

Signature: ______________________________________ ______/_______/______
[Date]

Name: ______________________________________
[Print Name]

If signing for a minor: ______________________________
[Print Minors Name]

Read by: ____
[Print Reader's Name]

Original date:
Revised: 01/04/2013
Approved:

BRAZOS VALLEY COMMUNITY HEALTH SERVICES

ADVANCE DIRECTIVE NOTIFICATION

You must make two decisions about your life in order to write an Advance Directive document. You must first decide what you want if faced with certain health situations. Secondly, you must communicate the information to others. This is done through an Advance Directive.

This document tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example)

When you complete and sign and date an Advance Directive the document is then used to help others understand your wishes and values about medical care in the case where you cannot speak for yourself.

It is important to give a copy of this document to all of your doctor's offices, your local hospital, family members who may need this information, your lawyer, and other persons who could be involved in these life decisions.

We are required to inform you of your right to have an Advance Directive.

Patient Name: ____________________________ Today's Date: _____________

BRAZOS VALLEY COMMUNITY HEALTH SERVICES

NOTIFICACION POR ADELANTADO

Tu tienes derecho de hacer Decisiones por Adelantada, Primero: Tienes que fijar una decision de tu situacion de salud. Segundo, tienes que comunicarle a otros de tus decisions que tomaste por Adelantado.

Este documento le indica a tu doctor que clase de cuidado tu quieres si tu estas indispuesto para hacer decisiones de salud (como en estado de coma, por ejemplo).

Cuando tu hallas completado y firmado tu Decision por Adelantado, este documento le ayudara a otros entender tus deseos del cuidado medico que deseas en caso de que no puedas hablar.

Es muy importante que le des una copia de este documento a la oficina de tu doctor, a el hospital de tu localidad y a los miembros de tu familia, tu licenciado y a otras personas que esten involucradas en las decisiones de tu vida.

Nosotros necesitamos la informacion de tus Derechos por Adelantado.

Nombre del Paciente: ___________________________ Fecha: ____________

Form Update & Effective 09.01.2014

AZ&ME Prescription Savings Program Certifications

PATIENT NAME: ____

PATIENT DATE OF BIRTH: ________________________

This patient has been found eligible for participation in the AZ&ME Prescription Savings Program based on review of his/her most current registration information provided when applying for services at HealthPoint.

☑ Patient states he/she has no other form of prescription drug coverage (private insurance, Medicaid, Medicare, etc.)

INCOME DETERMINATION: Number of People in Your Household = _____

Total combined household income? $__________ Monthly/Yearly (please circle correct term)

Patient's Documented Annual Income Is:

□	$35,000 for a Household of 1	□	$80,000 for a Household of 5
□	$48,000 for a Household of 2	□	$95,000 for a Household of 6
□	$60,000 for a Household of 3	□	$105,000 for a Household of 7
□	$70,000 for a Household of 4	□	$115,000 for a Household of 8

As evidenced by copies of one of the following: □ Form 1040 □ Form 4506T □ Form W-2 □ Payroll Check Stubs □ Letters from Employers □ Form 1099 □ Unemployment Documentation □ Social Security Statements □ Letter of Support

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____ I certify that I do not have any other type of insurance coverage for prescription medications and that if I obtain this coverage in the future I will notify you. (Includes private insurance, Medicaid, Medicare)

____ I certify that this form has been read to me in a language in which I am fluent and that I have provided true and accurate information. I also certify that I will notify the Medication Assistance Program of changes in my insurance status or income as they occur. I have had all of my questions answered and understand my responsibilities in this Medication Assistance Program.

____ I give permission for AZ&ME Prescription Savings Programs or its designee to review my records for audit purposes for the time period(s) that I receive services through this program.

_____ / _____ All information above is complete to the best of my ability.
(Initials of patient & agency representative)

____ ________________________
Patient Signature Date

____ ________________________
HealthPoint Representative Signature Date

Directions to Staff: Enter "AZ&Me" in the box at the bottom of the Patient Information screen under the "Insurance" section with the termination date of the registration period!

Your HealthPOINT Patient Portal is a great way to stay involved in your health care!

By using your Patient Portal, you can access your health records and communicate with your health center anytime you are on the Internet! To begin using your Patient Portal, just sign up by letting us know your personal (non-work) email address.

Once you log in to the secure server, you'll have access to:

Appointments
Book and keep track of appointments

Lab Results
Access and view lab results

Medical Records
View your personal health record

Messages
Send & receive messages from staff

Reminders
Receive health reminders

Contact Information
Keep your information up to date

Referrals
View & request referrals

Health Centers

Find the link at www.healthpoint-tx.com

Health POINT

Patient Portal