Midland Community Healthcare Services

A CARING HEART FOR THE WHOLE COMMUNITY

PATIENT INFORMATION

NAME____**DATE OF BIRTH**_____________________

SOCIAL SECURITY#__________________**MARITAL STATUS**: S M W D **PREFERRED LANGUAGE**_______________

RACE: ____American Indian/Alaska Native ____Native Hawaiian ____Other Pacific Islander ____Black/African American
____ Asian ____White **(Including Hispanic / Latino)** ____ More than one race ____Refuse

ETHNICITY: ____Hispanic ____Not Hispanic ____Other **VETERAN:** ____**Y**____**N**

GENDER: ____Male ____Female ____Transgender Male/Female to Male ____Transgender Female/Male to Female
____Don't know ____Other ____Choose not to disclose

SEXUAL ORIENTATION: ____ Straight or heterosexual ____Lesbian-Gay ____Bisexual ____Something else ____Don't Know
____Choose not to disclose

ADDRESS____CITY_______________STATE____ZIP___________
COUNTY________________________HOME PHONE_________________________CELL_____________________
WORK PHONE_________________________E-MAIL____
PREFERRED METHOD TO BE REACHED: **Home** ☐ **Cell** ☐ **Work** ☐ OKAY TO LEAVE A VOICEMAIL: **Yes** ☐ **No** ☐

PERSON RESPONSIBLE FOR BILL (IF NOT THE SAME AS ABOVE, COMPLETE THIS SECTION)

NAME____RELATIONSHIP TO PATIENT_____________________
ADDRESS____
CITY___________________________________STATE______ZIP_____________PHONE____________________
MOM SOCIALSECURITY: ____________________

INSURED PERSON (COMPLETE IF YOU HAVE INSURANCE)

NAME____RELATIONSHIP TO PATIENT_____________________
POLICY #____DATE OF BIRTH______________________________
ADDRESS____
CITY_______________________________STATE______ZIP_____________PHONE_______________________
EMPLOYER____PHONE__________________________

SELF DECLARATION INFORMATION

FAMILY SIZE_______ EST ANNUAL INCOME$ ____________

I, ______________________________, certify that the above information is true, correct and complete to the best of my knowledge. I also, understand that to receive financial assistance through MCHS I will need to provide the required documentation.

SIGNATURE OF PATIENT OR GUARDIAN_____________________________________ DATE_______________

I authorize my insurance company to pay directly to Midland Community Healthcare Services and assume full responsibility for payment of this account even if a third party is the "responsible party."

SIGNATURE OF PATIENT OR GUARDIAN____ DATE_________________

I authorize the release of medical information by Midland Community Healthcare Services to the insurance company on file.

SIGNATURE OF PATIENT OR GUARDIAN____ DATE_________________

Revised: 08/12/2019

Midland Community Healthcare Services

CONSENT FOR TREATMENT

I hereby apply for treatment at Midland Community Healthcare Services and give permission for any attending physician or non-physician provider of the Midland Community Healthcare Services staff, and for any consultant or assistant who he or she may call his or her aide, to administer any treatment and/or medication deemed necessary to my care and treatment. I authorize the employees of Midland Community Healthcare Services to assist my doctor(s) in any way deemed necessary for such treatment.

Patient Signature______________________________ **Date______________________**

Witness_______________________________________ **Date/Fecha__________**

CONSENTIMIENTO PARA RECIVIR TRATAMIENTO

Yo solicito tratamiento de Midland Community Healthcare Services y doy mi permiso para que cualquier medico del personal. Ya se al asistente, consultante, Y/O ayudante que el medico escoja para administrar el tratamiento o medicamento que sea necesario para mi cuidado y tratamiento. Ademas de eso autorizo a los empleados de MCHS de asistir a mi/s doctor/es de cualquier manera que se juzhue necesario, para semejante tratamiento.

Firma del Paciente_________________________________ **Fecha__________________________**

Testigo____ **Fecha__________________________**

PRESCRIPTION INSTRUCTIONS/PARA RELLENAR SU RECETA

______ Always ask for medicine refills during your appointment. / Favor de pedir más medicina cuando venga a su cita.

______ If you request a medication refill when you do not have a scheduled appointment please allow us **ONE WEEK** TO ARRANGE YOUR REFILL. / Para recibir otra receta, háblenos **UNA SEMANA** antes de que se le acabe la medicina para darnos suficiente tiempo para rellenar la receta.

______ Do not wait until you are completely out of medicine. Please call us one week in advance. /No espere hasta que se acabe su medicina para pedir mas. Por favor llame una semana antes.

Patient Signature/Firma_____________________________ **Date/Fecha______________**

Revised: 01/22/2018

Midland Community Healthcare Services

The success of any course of medical treatment depends on the quality of the relationship between the patient and the medical care providers. Lines of communication must remain open. The Patient Bill of Rights will help you know what to expect during your visit. The Patient Responsibilities will help you know what is expected of you as a patient. If the patient is a minor or has a guardian, the rights and responsibilities of the patient transfer to the parent(s) or guardian.

PATIENT BILL OF RIGHTS – As a patient of this Clinic, you have the right:

- To considerate, respectful care and to participate in the development and implementation of your plan of care.
- To make decisions regarding your care.
- To be informed of your health status, be involved in your care planning and treatment, to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of your actions.
- To formulate advance directives and to have Clinic staff and practitioners who provide care in the Clinic comply with these directives to the extent permitted by law.
- To every consideration of your personal privacy concerning your medical care and health information.
- To expect reasonable safety insofar as the Clinic practices and environment are concerned to include a setting free from verbal or physical abuse or harassment.
- To expect that all communications and Clinical records pertaining to your care be treated as confidential, with the ability to access information contained in your Clinical records within a reasonable time frame.
- To be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.
- To obtain from your physician completed and current information concerning his/her diagnosis and treatment in understandable terms.
- To receive from your physician information necessary to give informed consent prior to the start of a procedure and/or treatment.
- To expect that within its capacity, the Clinic must reasonably respond to patient request for services.
- To obtain information as to any relationship of the Clinic to other health care or educational entities insofar as your care is concerned.
- To be advised if the Clinic proposes to engage in or perform human experimentation affecting your care or treatment.
- To expect reasonable continuity of care.
- To examine and receive an explanation of your bill regardless of the source of payment.
- To know what Clinic rules and regulations apply to your conduct as a patient.
- To treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin or sources of payment for care.
- To know the identity and professional status of individuals providing service and to know which physician or other practitioner is primarily responsible for your care.
- Of access to people outside the Clinic by means of visitors, and by verbal and written communication.
- To consult with a specialist at your own request and expense.
- To know if the Clinic has relationships with outside parties (i.e., educational institutions, other health care providers, or insurers) that may influence your treatment and care.

PATIENT RESPONSIBILITIES – You are responsible for:

- Providing, to the best of your knowledge, accurate and complete information about present complaints, past illness, hospitalization, medications, and other matters relating to your health.
- Following the treatment plan recommended by the practitioner.
- Reporting unexpected changes in your condition to the responsible practitioner.
- Making it known whether you clearly comprehend a contemplated course of action and what is expected of you. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioner’s orders, and as they enforce the applicable Clinic rules and regulations.
- Keeping appointments and, when you are unable to do so for any reason, notifying the responsible practitioner or the Clinic.
- For your actions if you refuse treatment or do not follow the practitioner’s instructions.
- Assuring that the financial obligations of your health care are fulfilled as promptly as possible.
- Following Clinic rules and regulations affecting patient care and conduct.
- Being considerate of the rights and property of other patients and Clinic personnel and for assisting in the control of noise, smoking, and number of visitors.

PATIENT PROBLEMS AND GRIEVANCES – At Midland Community Healthcare Services we strive to provide the best patient care. However, if you should encounter a problem with your care, report the problem to the Clinic Manager right away. If you still do not feel that the problem has been resolved to your satisfaction, you may: 1) contact the Department Director, 2) report the problem on your Patient Satisfaction Survey, or 3) telephone Midland Community Healthcare Services Administration @ (432) 699-3820, or write a letter to Midland Community Healthcare Services, P.O. Box 5576, Midland, Texas, 79704-5576.

Or you can contact:

- Department of State Health Services Complaint Hotline (888)973-0022
- United States Department of Health and Human Services Office of Civil Rights (800)368-1019

I acknowledge that I have received a copy of Midland Community Healthcare Services’ Patients Rights and Responsibilities.

______________________________________ ______________________________

Patient Signature (Parent / Guardian, if applicable) Date