

## PATIENT RIGHTS & RESPONSIBILITIES

### YOUR RIGHTS AS A PATIENT

1. You have the right to considerate and respectful care regardless of race, color, age, gender, gender identity, sexual orientation, religion, national origin, language spoken (including if you don't speak or understand the English language), handicap status, or the existence of Advance Directive.
2. You have the right to a safe and private environment for patient care. This includes both personal privacy and informational confidentiality. Case discussion, consultation, examination, and treatment are to be carried out with discretion.
3. You have the right to information regarding your medical care and treatment. First Care Clinic will rely on the provider and/or nurse to keep you informed concerning your progress, diagnosis and treatment modality. You, and when necessary, your surrogate decision-maker, should participate in decisions relating to your care.
4. You have the right to receive from your provider the information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. You have the right to know the name of the person responsible for the procedure and/or treatment.
5. You and your surrogate decision-maker have the right within legal boundaries, to refuse treatment and be informed of the medical consequences of your action.
6. You have the right to request information and assistance to prepare Advance Directives consistent with Kansas Law.
7. You have the right to expect that within its capacity, First Care Clinic will make reasonable response to your request for services. The Health Center will provide evaluation services, and/or referral as indicated by the urgency of the case.
8. You have the right to consent or refuse to participate in experimental, investigational, educational, or research activity related to your care.
9. You have the right to have explained to you the First Care Clinic rules, regulations, policies, procedures, and charges that relate to your care.
10. You have the right to express concerns, complaints, or care-related concerns.

In many situations, First Care Clinic will not release patient-identifiable medical information outside this institution without your written authorization. You may revoke your authorization at any time by notifying the clinic in writing. However, in circumstances defined by law, health care providers are required to report information to the appropriate persons. For example, it must be reported when there are suspicions of child abuse or neglect, or threat of harm to self or others.

### YOUR RESPONSIBILITIES AS A PATIENT

1. You are responsible to provide accurate and complete information about your present and past health problems and illnesses, hospitalizations, medications, and your response to current treatment.
2. You are responsible to learn about your illness and care, to ask about care alternatives including the risks and benefits of each and to make your preference clear to the health professionals involved in your care.
3. You are responsible to follow the treatment plan recommended by medical personnel attending your care. You are responsible for the consequences for failure to follow instructions for refusal of treatment or for failure to follow recommendations for your continuing care when referred from First Care Clinic to a specialty medical service provider.
4. You are responsible to follow First Care Clinic rules and regulations affecting patient care and personal conduct.
5. You are responsible to be respectful and considerate of the rights of other patients and First Care Clinic's personnel and property.
6. You are responsible to express concerns, complaints, or care-related conflicts to your provider or a member of First Care Clinic staff.
7. The undersigned guarantees payment in accordance with clinic payment policies.

I understand the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all the conditions for treatment at First Care Clinic as described above. If I am not the patient, I certify that I am authorized by law to agree to these conditions of Treatment on the patient's behalf.

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Signature of patient or authorized agent

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Relationship to patient

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Date

# FIRST CARE CLINIC POLICIES

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## **Financial Responsibility Policy**

The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment of our fees in full. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf (if applicable). However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim or if you or your physician elect to continue past your approved period, you will be responsible for your balance in full.

I authorize my insurer to pay any benefits directly to First Care Clinic the full and entire amount of bill incurred by me or the above named patient.

## **Co-Pay Policy**

Some health insurance carriers require a co-pay for services rendered. It is expected and appreciated at the time of service.

## **Cancellation / No Show Policy**

As a patient of First Care Clinic, I understand that it is very important to keep my scheduled appointments and I understand the following:

- I am urged to call within 24 hours prior to canceling a medical or dental appointment.
- I am required to confirm my dental appointments by phone or in person 24 hours prior to my appointment. Failure to do so will result in the appointment being counted as a no-show.
- If I have 3 (medical or dental) no-shows in a 12 month period, I will be placed on same-day status for a period of 6 months.
- If I arrive 10 minutes or more past my scheduled appointment time, I may be rescheduled and the appointment will be counted as a no-show.
- New patients who do not confirm or show for their dental appointment will be unable to schedule another appointment until 6 months after the original appointment.

I agree that I have read the above policies regarding my responsibility to First Care Clinic for providing medical/dental services to me or the above named patient.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

## **Consent for Treatment**

I hereby authorize First Care Clinic, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I acknowledge that I have received a copy of First Care Clinic’s Notice of Privacy Practices effective September 17, 2013.

\_\_\_\_\_  
Signature of Patient/Patient Representative Date

\_\_\_\_\_  
Relationship to Patient

**PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION**

I give First Care Clinic permission to disclose my protected health information to the following individuals involved in my health care and/or payment for health care goods and services.

*If you decline to give such permission, leave the following blank.*

- 1) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_
- 2) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_
- 3) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_
- 4) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_
- 5) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_
- 6) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Patient Representative Date

\_\_\_\_\_  
Relationship to Patient

**Copy to be maintained in Patient’s health record.**



## PATIENT INFORMATION SHEET

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: Male / Female / Other: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email Address: \_\_\_\_\_ (required for patient portal access)  
If you don't want to receive patient portal registration information via email, please check here:

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Number of People in Household: \_\_\_\_\_ Total Household Income: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Primary Dentist: \_\_\_\_\_

Advanced Directive: Yes  No  Are you a veteran? Yes  No

Do you have health insurance? Yes  No  Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_

Do you have dental insurance? Yes  No  Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_

Race/Ethnicity: American Indian/Native Alaskan  Preferred Language: English   
Asian  Spanish   
Black/African American  Other: \_\_\_\_\_  
Hispanic or Latino (All Races)  Interpreter Needed   
Pacific Islander   
White (Not Hispanic or Latino)   
Unknown/Other

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### Health Insurance Policy Holder Information (If different from patient)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### Dental Insurance Policy Holder Information (If different from patient)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### Person Responsible to Pay the Bill – Guarantor (If different from patient)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_



PATIENT CHECK-IN

Last Medical Visit \_\_\_/\_\_\_/\_\_\_ Provider \_\_\_\_\_

Last Dental Visit \_\_\_/\_\_\_/\_\_\_ Provider \_\_\_\_\_

Last Eye Exam \_\_\_/\_\_\_/\_\_\_ Provider \_\_\_\_\_

Last Tetanus Vaccine \_\_\_/\_\_\_/\_\_\_ Last Influenza Vaccine \_\_\_/\_\_\_/\_\_\_ Last Pneumonia Vaccine \_\_\_/\_\_\_/\_\_\_

Last Colonoscopy \_\_\_/\_\_\_/\_\_\_ Last Bone Density Test \_\_\_/\_\_\_/\_\_\_

(FEMALES ONLY) Last pap \_\_\_/\_\_\_/\_\_\_ at \_\_\_\_\_ (Clinic Name)

Last mammogram \_\_\_/\_\_\_/\_\_\_ at \_\_\_\_\_ (Clinic Name)

Last Breast Exam \_\_\_/\_\_\_/\_\_\_ Last Menstrual Period \_\_\_/\_\_\_/\_\_\_

Are you pregnant, nursing or on birth control? [ ]Yes [ ]No If pregnant, when is your due date? \_\_\_\_\_ Who do you see for OB care? \_\_\_\_\_

(\*If taking birth control, please be aware that any prescribed antibiotics could offset its effectiveness)

Pharmacy: \_\_\_\_\_

Do you have pharmacy insurance to help pay for medication? [ ]Yes [ ]No

Have you ever taken any meds for Osteoporosis or weak bones? [ ]Yes [ ]No For Example: ( \_\_\_\_\_ )

Have you ever have any complications following dental treatment? [ ]Yes [ ]No

If yes, please explain: \_\_\_\_\_

Have you had any hospitalizations in the past 2 years? [ ]Yes [ ]No

If yes, please explain? \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_





**HOUSEHOLD ASSESSMENT INFORMATION**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

I understand that by filling out the information below I will be eligible to participate in the sliding fee scale program subject to income guidelines. I agree to pay the full and entire amount for treatment given to me or to the above named patient as determined by the sliding fee scale. I also understand that I will be considered as a “full-pay” patient after the first visit and for every visit thereafter until proof of income is provided.

\_\_\_\_\_  
**Patient/Guarantor Signature**

\_\_\_\_\_  
**Date**

HOUSEHOLD INFORMATION					
PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD, INCLUDING YOURSELF					
NAME	RELATIONSHIP	D.O.B.	AGE	ANNUAL INCOME	SEX

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**FOR OFFICE USE ONLY**

**IDENTIFICATION / ADDRESS:** DRIVER’S LICENSE, EMPLOYMENT I.D.,  
 BIRTH CERTIFICATE, S.S. CARD, UTILITY BILL, PHONE, CABLE BILL

**YES NO**

**INCOME:** PRIOR YEAR TAX RETURN, 2 MOST RECENT PAY STUBS,  
 UNEMPLOYMENT STATEMENT, DISABILITY STATEMENT,  
 DOCUMENTATION OF GOVERNMENT ASSISTANCE, CHILD  
 SUPPORT/ALIMONY

**YES NO**

**VERIFIED BY:** \_\_\_\_\_



CLINIC

PATIENT NOTIFICATION ACKNOWLEDGEMENT AND CONSENT FORM

\_\_\_\_ (Patient initials) Consent to Voice Message, Email or Text Message Usage for Appointment Reminders and Other General Health Information Notifications\*. By initialing this paragraph, I consent and acknowledge that I understand that I may be contacted via telephone voice message, email and/or text messaging for patient appointment reminders and/or to receive general health information notifications from First Care Clinic, Inc ("FCC"). Appointment reminders may include information such as, patient name, appointment time and date, steps for rescheduling an appointment, a generic reminder to schedule an appointment for a preventative care service (e.g. annual physical, flu shot) and/or comparable information. Appointment reminders shall not include details related to health care services to be provided. General health information notifications may include information such as, or equivalent to, announcements for health fairs, flu shot clinics, sports physical days, health screenings or other special events sponsored by FCC. I hereby consent that I wish to receive such messaging from FCC for the types of communications stated in the previous sentences by voice message to the telephone number identified below, by text message to the cell phone identified below and/or by email communication to the email address identified below. I understand that this request to receive voice messages, emails and text messages will apply to all future appointment reminders and general health information notifications unless I request a change and I specifically revoke my consent in writing (see below).

The telephone number that I authorize to receive voice messages for appointment reminders and general health information notifications from FCC is \_\_\_\_\_.

The cell phone number that I authorize to receive text messages for appointment reminders and general health information notifications from FCC is \_\_\_\_\_.

The email address that I authorize to receive email messages for appointment reminders and general health information notifications from FCC is \_\_\_\_\_.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient/Patient Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

*\*First Care Clinic does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your cell phone carrier for details and pricing as needed).*

**Revocation for future voice message/text message/email communications**

\_\_\_\_ (Patient initials) I hereby revoke my request to receive any and all future appointment reminders and general health reminders/information via voice message, text message and/or email.

Patient Name: \_\_\_\_\_

Patient/Patient Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_