Health Ministries Clinic
COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

FULL NAME		**PREFERRED NAME**	
DATE OF BIRTH (MM/DD/YY)	**SSN#**	**GENDER AT BIRTH** ☐ Male ☐ Female	
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
MAILING ADDRESS (IF DIFFERENT FROM ADDRESS)	**MAILING CITY**	**MAILING STATE**	**MAILING ZIP CODE**
HOME PHONE	**CELL PHONE**	**WORK PHONE**	
ADDITIONAL/FORMER NAMES (EX. MAIDEN NAME)	**LEGAL MARITAL STATUS**	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner	
EMAIL ADDRESS (REQUIRED FOR PATIENT PORTAL ACCESS)	**Employer:**	☐ Full time ☐ Part time ☐ PRN ☐ Student	

PHARMACY ☐ Health Ministries Clinic Pharmacy ☐ Other Pharmacy (specify): _____

TRANSPORT Do you need Transportation Assistance to and from your appointments at Health Ministries Clinic? ☐ Yes ☐ No

RACE
(Check all that apply)

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Asian
- ☐ Vietnamese
- ☐ Filipino
- ☐ Korean
- ☐ Japanese
- ☐ Asian Indian
- ☐ Chinese
- ☐ Declined to Specify

DO YOU IDENTIFY AS HISPANIC/LATINO?

- ☐ No
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Other Hispanic Latino

HOUSING
Are you currently experiencing homelessness?

- ☐ Yes
- ☐ No

IF YES: are you utilizing any of the following?

- ☐ Transitional
- ☐ Doubling Up
- ☐ Street
- ☐ Other (please specify): _____

DO YOU LIVE IN PUBLIC HOUSING?

- ☐ Yes ☐ No

POPULATIONS
(Check all that apply)

- ☐ Veteran
- ☐ Farm Worker
- ☐ Migrant Worker
- ☐ Seasonal Worker

PREFERRED LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Interpreter Needed
- ☐ Other: _____

GENDER IDENTITY*

- ☐ Male ☐ Female
- ☐ FTM ☐ MTF
- ☐ Nonbinary ☐ Decline to specify
- ☐ Other (please specify):

SEXUAL ORIENTATION*
(Not required if under the age of 18)

- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Lesbian/Gay/Homosexual
- ☐ I do not know
- ☐ Decline to Specify
- ☐ Other (please specify): _____

PREFERRED PRONOUNS

He/Him She/Her They/Them
Other (please specify): _____

**Sexual Orientation and Gender Identity can play a significant role in determining health outcomes. Please see the front desk or ask your healthcare team if you have questions about disclosing this information.*

HOW DID YOU HEAR ABOUT HMC?

☐ Social media ☐ Flyers ☐ Google
☐ Friend ☐ Other: _____

☐ Check if Same as Patient — RESPONSIBLE PARTY *(PERSON RESPONSIBLE FOR PAYING ON PATIENT ACCOUNT)*

FULL NAME		**SSN#**	
DATE OF BIRTH	**EMPLOYER**	**CONTACT NUMBER**	
ADDRESS	**CITY**	**STATE**	**ZIP CODE**

Health Ministries Clinic
COMMUNITY HEALTH CENTER

PATIENT NAME:	DOB:

INSURANCE INFORMATION (HMC WILL NEED A COPY OF YOUR INSURANCE CARD(S))

PRIMARY HEALTH INSURANCE:		SECONDARY HEALTH INSURANCE:	
HEALTH INSURANCE COMPANY		HEALTH INSURANCE COMPANY	
NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE):		NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE):	
GROUP #	POLICY #	GROUP #	POLICY #
POLICY HOLDER'S DATE OF BIRTH (IF DIFFERENT FROM ABOVE):		POLICY HOLDER'S DATE OF BIRTH (IF DIFFERENT FROM ABOVE):	
POLICY HOLDER'S RELATIONSHIP TO PATIENT ☐ Self ☐Spouse ☐Parent ☐Other_____		POLICY HOLDER'S RELATIONSHIP TO PATIENT ☐ Self ☐Spouse ☐Parent ☐Other_____	

PRIMARY DENTAL INSURANCE

DENTAL INSURANCE COMPANY
NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE)
POLICY HOLDER'S DATE OF BIRTH (IF DIFFERENT FROM ABOVE)
POLICY HOLDER'S RELATIONSHIP TO PATIENT ☐ Self ☐Spouse ☐Parent ☐Other_____

HOUSEHOLD INCOME

The following information is used to determine if you may qualify for discounted fees and services.
This information can be updated at any time.

Have insurance? You still may qualify for a discount!

Sliding fee scales also apply for possible discounts at the pharmacy, along with HMC appointments.

Number in Household	Annual Household Income				
	Slide A	Slide B	Slide C	Slide D	No Slide: (>200% of FPG)
1	☐ < $15,060	☐ $15,061-$22,590	☐ $22,591-$26,355	☐ $26,356-$30,120	☐ > $30,121
2	☐ < $20,440	☐ $20,441-$30,660	☐ $30,661-$35,770	☐ $35,771-$40,880	☐ > $40,881
3	☐ < $25,820	☐ $25,821-$38,730	☐ $38,731-$45,185	☐ $45,186-$51,640	☐ > $51,641
4	☐ < $31,200	☐ $31,201-$46,800	☐ $46,801-$54,600	☐ $54,601-$62,400	☐ > $62,401
5	☐ < $36,580	☐ $36,581-$54,870	☐ $54,871-$64,015	☐ $64,016-$73,160	☐ > $73,161
6	☐ < $41,960	☐ $41,961-$62,940	☐ $62,941-$73,430	☐ $73,431-$83,920	☐ > $83,921
7	☐ < $47,340	☐ $47,341-$71,010	☐ $71,011-$82,845	☐ $82,846-$94,680	☐ > $94,681
8	☐ < $52,720	☐ $52,721-$79,080	☐ $79,081-$92,260	☐ $92,261-$105,440	☐ > $105,441

☐ More than 9+ members in household—*Please ask the Front Desk for additional information*

☐ ***I DO NOT QUALIFY FOR THE SLIDING FEE SCALE, AND/OR CHOOSE TO DECLINE***

☐ ****I ATTEST THAT I AM ABOVE 200% OF FEDERAL POVERTY GUIDELINES (FPG)****

HMC OFFICE USE ONLY

If the above patient needed help filling out this form and the patient and/or legal representative is present

Staff Name: _____ Staff Signature: _____ Date Completed: _____

Health Ministries Clinic
COMMUNITY HEALTH CENTER

Patient Communication Authorization

Patient Name: ____ DOB: ______/_____/________

I authorize Health Ministries Clinic (HMC) to share my personal health information with the listed representative(s) below. I understand this authorization is voluntary. I understand that once information is disclosed, it may be disclosed by the third party(s), and the information may not be protected by Federal Privacy Laws or Regulations. I understand this consent will remain in effect until I request an update. This Authorization is for use, pursuant to the HIPPA Privacy Rules, if you are authorizing the release of medical/health information to another individual for access on an on-going basis to assist with your care and maintaining your information. You understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding **the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.** You have the right to revoke this authorization at any time in person at HMC. The revocation is only effective after it is received and logged. Any use or disclosure made prior to a revocation is not included as part of the revocation. The purpose of this form is for HMC to communicate the patient's healthcare information to a 3rd party listed below. **This form expires one year from the date of signature unless revoked beforehand.**

IF YOU ARE NOT AVAILABLE, MAY WE LEAVE A VOICE MESSAGE?

☐ No, do not leave a voice message ☐ Yes, please leave a voice message

IF YOU ARE NOT AVAILABLE, WHO MAY WE COMMUNICATE WITH? **PLEASE CHECK ALL THAT APPLY.**

☐ **Communicate with SELF ONLY**

☐ Name: ____ Phone: (_______) _______-__________
Relationship to Patient: _____________________

☐ Any Information ☐ Appointment Information ☐ Consent to treat minor patient* (For patients under the age of 18)
☐ Emergency Contact ☐ Test Results
☐ Billing Information ☐ Pharmacy

☐ Name: ____ Phone: (_______) _______-__________
Relationship to Patient: _____________________

☐ Any Information ☐ Appointment Information ☐ Consent to treat minor patient* (For patients under the age of 18)
☐ Emergency Contact ☐ Test Results
☐ Billing Information ☐ Pharmacy

☐ Name: ____ Phone: (_______) _______-__________
Relationship to Patient: _____________________

☐ Any Information ☐ Appointment Information ☐ Consent to treat minor patient* (For patients under the age of 18)
☐ Emergency Contact ☐ Test Results
☐ Billing Information ☐ Pharmacy

*By selecting consent to treat, I, as the parent or guardian** of the minor aged patient agree to allow the following persons checked above to give consent to the treatment of said minor.
**Legal guardians please bring your paperwork noting your relation to the minor, if applicable

____ ______/_____/_______
Patient or Parent/Guardian Name Printed **Date**

____
Patient or Parent/Guardian Signature

Health Ministries Clinic
COMMUNITY HEALTH CENTER

PAYMENT AGREEMENT

I agree all payments and co-payments must be paid at the time of service. I understand to be eligible for the sliding fee scale I must provide proof of income. Proof may consist of my previous tax return, paycheck stubs (3), unemployment printout, etc. This information must be provided at the time of visit for the sliding scale to be offered. I understand if my account is 90 days past due, I will receive a letter stating I have to pay on my account or I am subject for my past due account being written off to bad debt. I understand partial payments will be accepted unless otherwise negotiated.

INSURANCE FILING

I hereby authorize Health Ministries Clinic (HMC) to furnish information to insurance carriers concerning my illness and treatments. I understand my insurance will be filed as a courtesy and I agree to be financially responsible for any balance due to Health Ministries Clinic, Inc. I understand failure to provide HMC with current, accurate insurance information will result in all charges becoming my responsibility or responsible party. All co-pays and co-insurance fees are due at time of service. These payments do not guarantee payment in full. Statements will be mailed for charges exceeding the initial payment made. I understand I will be responsible for any charges not paid by my insurance.

MEDICARE PATIENTS

Patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. I authorize Medicare benefits be made either to me or on my behalf to Health Ministries Clinic, Inc. for any services furnished me by Health Ministries Clinic, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

ATTENDANCE AGREEMENT

I agree to contact HMC via phone, website or patient portal before the event that I need to cancel or reschedule my appointment. I understand all appointments (i.e., medical, dental and behavioral health) are considered a no-show if I fail to report to the clinic for a scheduled appointment. A no-show will be implemented when a patient shows for their appointment 10 minutes or more after the appointment. I understand I need to arrive 15 minutes before my appointment time, to complete the required check-in process and pay fees at the reception desk. I agree if I have two (2) no-shows within a one-year period, I will be required to meet with a Patient Care Coordinator and/or designee before scheduling another appointment. I understand if I have a third (3) no-show in a one-year period, I may be informed I will no longer have the ability to schedule future appointments or possibly be placed on "same-day scheduling" for a minimum of six (6) months. I understand If I have scheduling privileges suspended, I may request that my status be reviewed by the Chief Executive Officer and/or designee. I acknowledge I understand the expectations about the need to keep my scheduled appointment and the potential consequences if this fails to happen.

ELECTRONIC HEALTH INFORMATION TECHNOLOGY

HMC participates in electronic Health Information Technology (HIT). This technology allows a provider or a health plan to make a single request through a Health Information Organization (HIO), to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or healthcare operations. HIO's are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Second, you may restrict access to all of your information through an HIO (except by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIO's, please visit http://www.KanHIT.org.

PATIENT CONSENT FOR SCRIBE AND TELEHEALTH SERVICES

I understand that HMC provides telehealth services and uses audio scribe services. I give my permission to be audio recorded during my visits, should my provider utilize such services. I acknowledge that my participation is voluntary and that I may revoke this consent at any time providing HMC a 30-day written notice.

PATIENT ACKNOWLEDGEMENT & NOTICE OF PRIVACY PRACTICES

I acknowledge that HMC has given me the right to review and secure a copy of the Notice of Privacy Practices, which describes how health information about me may be used and disclosed, as well as a complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that HMC reserves the right to change the terms of this notice periodically, and that I may contact Health Ministries Clinic at any time to obtain the most current copy of these documents. I understand that if I have any questions regarding any of these documents, I can contact HMC. A paper copy may be obtained at the reception desk.

I hereby acknowledge that I have read, fully understand, and accept the terms of the financial guidelines and policies stated above.

PATIENT NAME (PRINTED)	PATIENT DOB:
PATIENT OR PARENT/GUARDIAN SIGNATURE:	**DATE:**

☐ Patient or Parent/Guardian refuses to acknowledge Notice of Privacy Practices

Health Ministries Clinic
COMMUNITY HEALTH CENTER

Patient's Rights and Responsibilities

Health Ministries Clinic (HMC) is a community health center that exists to promote and improve the quality of life by providing integrated healthcare. Each patient who entrusts HMC with their care is treated with dignity, respect, and compassion. HMC acknowledges that all patients have fundamental rights and is dedicated to honoring these rights. Every individual should be informed of the patient's rights and responsibilities before being provided care.

PATIENT'S RIGHTS

While patients are in the care of HMC, staff is committed to respecting patient's privacy and their right to be an active partner in making decisions about their health care. Patients have a right to:

1. Be treated with courtesy, dignity, and respect with consideration for personal, cultural, psychosocial, religious, and spiritual preferences regardless of race, color, national origin, age, disability, sexual orientation, gender identity or language preference.
2. Expect communications and records pertaining to their care, including the source of payment, to be kept confidential.
3. Expect any discussions or consultations to be kept private; persons not directly involved in care are not present without patient and/or guardian's permission.
4. Effective communication that considers language needs, as well as hearing, speech and visual impairments.
5. Request information about fee schedules and payment policies.
6. Accurate and honest billing practices.
7. Request a reasonable estimate of the clinical cost of care and/or may receive one prior to treatment.
8. Have complete information about health status, diagnosis, prognosis, and treatment.
9. Receive comprehensive information to make informed treatment decisions.
10. Be respected related to the right to refuse care, treatment, or services in accordance with laws and regulations.
11. Choose a provider that aligns with treatment goals.
12. To have access to, request amendment to, and obtain information on disclosures of patient's health information, in accordance with law and regulation.
13. Express suggestions or grievances to a member of clinic management.
14. Participate in decisions about their health care, unless medically inadvisable.
15. Lawfully assign someone to exercise the rights indicated above on their behalf, if unable to exercise said rights themselves.

PATIENT'S RESPONSIBILITIES

While you are a patient of Health Ministries Clinic patients are expected to:

1. Provide, to the best of their knowledge, accurate information about present complaints, past illnesses, hospitalizations, medications.
2. Report unexpected changes in their health to the nurse or provider.
3. Ask questions to achieve better understanding (treatments, procedures, medications, etc.)
4. Be considerate of other patients and clinic staff.
5. Be a partner in their care.
6. Keep scheduled appointments and/or cancel/reschedule them as early as possible to allow others a chance to be seen.
7. Inform the health care provider if they feel uncomfortable about a recommended plan of treatment.
8. Provide accurate financial and insurance information needed to determine ability to pay for services.
9. Make reasonable efforts to pay for services at the time of the visit, or according to their payment plan. If this is not possible, notify HMC.
10. Provide the information needed to help with assistive services.
11. Notify HMC about changes regarding their financial situation or health insurance.
12. Respect the rights and property of other patients, staff, and other persons within HMC facilities.
13. Know the regulations and rules that apply while a patient inside the clinic.
14. Understand that aggressive behavior (including but not limited to physical assault, verbal harassment, abusive language, sexual language directed at others, threats) can result in dismissal from HMC.

I HAVE READ AND UNDERSTAND THE POLICIES AS STATED AND AGREE TO ABIDE BYTHEM.

_____ _____/_____/_____

Patient Name (Printed) Patient Date of Birth

_____ _____/_____/_____

Patient or Parent/Guardian Signature Date

Health Ministries Clinic
COMMUNITY HEALTH CENTER

Pediatric Health History

Patient Name: _____ DOB: ____/____/_____
Last Name First Name Middle Initial

Date: ____/____/_____

Medical History

How old was the mother when the child was born? _____

Which pregnancy was this child for the mother? _____

Did the mother use any of these substances during pregnancy?

☐ Alcohol—How much? _____

☐ Illegal Drugs—What? _____

☐ Smoking—How much? _____

Was this child born full term? ☐ Yes ☐ No, how early/late? _____

How much did the child weigh at birth?_____

Was the child healthy at birth? ☐ Yes ☐ No, specify: _____

Has the child ever been hospitalized?

Age of Child	Reason of hospitalization
_____	_____
_____	_____
_____	_____

Has the child ever had surgery?

Age of child	Type	Reason for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this child have any history of the following?

☐ Allergies ☐ Seizures ☐ Other: _____

☐ Asthma ☐ Eczema - Atopic Dermatitis

☐ ADD/ADHD ☐ Recurrent Ear Infections ☐ Other: _____

List all reactions to medicine, foods and other agents. ☐ N/A

Allergy	Reaction	Side Effect

Does this child use any medications on a routine basis? ☐ Yes ☐ No

Medication	Dose/Frequency	Reason

Immunizations:

Are Immunizations up to date? ☐ **Yes** ☐ **No,** specify: _____ **Please provide a copy of the record.**

Development

Do you have any concerns about your child's development?

_____

_____

_____

If school age: Grade _____ School _____

Social History

Please list all persons who live with the child.

Name	Age	Relationship to the child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any pets in the home? ☐ Yes ☐No

How many?_____What kind of pet(s)? _____

Are there any smokers in the home? _____

Smoke outside only? _____

Family History

Do any of the child's family members (parent, sibling) have any of the following?

- ☐ Allergies _____
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Birth Defects
- ☐ Mental Retardation
- ☐ Death before age 21; Age ____ Cause _____
- ☐ Eczema - Atopic Dermatitis
- ☐ Seizures
- ☐ Other (specify) _____

What concerns would you like to discuss with the doctor today? _____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or clinic staff responsible for any errors or omissions that I may have made in completing it.

_____
Signature of Patient or Guardian Date

_____
Print name of Patient or Guardian Relationship

HMC OFFICE USE ONLY

This section is to be filled out by HMC staff. IF, the above patient needed help filling out this form and the patient and/or legal representative is present.

Staff Name: _____ Date Completed: ____/____/_____

Health Ministries Clinic
COMMUNITY HEALTH CENTER

Proxy Access Request and Authorization Form

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: ____/____/_____
Last Name First Name Middle Initial MM DD YYYY

Address: _____ Email: _____
Number Street City State Zip Code

PROXY INFORMATION:

Proxy is an authorized individual granted access to the Patient Portal included but not limited to a parent or legal guardian, family caregiver, home health aide or a healthcare power of attorney.

Proxy Name: _____ Date of Birth: ____/____/_____
Last Name First Name Middle Initial MM DD YYYY

_____ _____
Phone Number Email Address

PLEASE CHECK ONE OF THE BOXES BELOW THAT BEST DESCRIBES THE PROXY ACCESS REQUEST

(Please note that for all types of proxy access, the patient's chart will be accessed through the proxy's Patient Portal account.)

ADULT PATIENT: ☐ **COMPLETE ACCESS**

Access to another adult's Patient Portal health record. (This also applies to Emancipated Minors. Minors must provide proof of emancipation.)

- ☐ **CAPABLE ADULT PATIENT:** Patient should sign this form to provide authorization for release of their medical information. Authorization for proxy access is valid until revoked by patient.
- ☐ **LEGAL GUARDIAN OF ADULT PATIENT:** Adults who have a surrogate relationship with another adult through a legal arrangement.

SELECT THE OPTION BELOW THAT BEST DESCRIBES THE GUARDIANSHIP:

- ☐ Legal Guardian (court order)
- ☐ Power of Attorney for Health Care
- ☐ Other: _____

- If you are the legal guardian or have a durable power of attorney for healthcare for this patient, then this request must be accompanied by a copy of the legal paperwork verifying our authority to have access to the patient's medical information.
- You must notify Health Ministries Clinic immediately in case of any change in authority.

ADOLESCENT-MINOR PATIENT: ☐ **COMPLETE ACCESS** ☐ **LIMITED**

Access to minor child's Patient Portal health record. Individuals requesting access must have parental rights / legal guardianship rights.

MY RELATIONSHIP TO THE CHILD IS:

- ☐ Parent
- ☐ Legal Guardian
  - Must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient

Select one:

- ☐ **Child Aged 14-17 Patient:** Access to your teenage child's Patient Portal Record.
  - Health Ministries Clinic requires patients ages 14-17 to specifically indicate whether they permit their parent(s) or guardian(s) to have access to the portions of the patient's medical information specially protected under state laws, this includes reproductive, STD, mental health, and substance abuse information, by signing a separate agreement form.
  - When the patient becomes 18 years old, parent access will be turned off.

Health Ministries Clinic
COMMUNITY HEALTH CENTER

Authorization:

- By signing this proxy request, I understand that I am giving my permission for Health Ministries Clinic, Inc. to disclose my protected health information (PHI) through the Patient Portal to my proxy. Information includes but is not limited to: health summary, current problem list, current medications, lab results, appointment information including provider notes. By giving my proxy **Complete Access** I understand my proxy will have full access to my patient portal. By giving my proxy **Limited Access** I understand that my proxy will only have access to; my doctor, dental summary, growth chart, inbox and clinic hours.
- The information available to my proxy may include information relating to: (1) acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, (4) mental or behavioral health or psychiatric care, (5) pregnancy testing or (6) birth control.
- This proxy request includes records that were created or existing on or before the date this form was signed as well as records that are created after the date this form is signed.
- I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that such a revocation will not have any effect on any information already released to my proxy.
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal or Kansas State privacy laws.

By signing below, proxy acknowledges and agrees that:

- I will be using my own portal account at Health Ministries Clinic to access the above patient's portal account (i.e. Patient Portal or Healow app).
- For minors:
  - I have parental rights or legal guardianship rights to access this child's record.
  - I have not been denied periods of physical placement by the court system for this child.
  - Communication must be sent from the child's record and responses will be received in the child's record. Portal alerts will be sent to the e-mail address entered under the Parent/Legal Guardian ("Proxy") Information.

Legal Guardians:
Any documents, if any, I have provided in support of my right to access the patient's protected health information, are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify Health Ministries Clinic in writing of the change in authority and mail it to the Health Information Management Department.

☐ **By checking this box, I acknowledge that I cannot access the patient portal and that I reject the use of proxy access.**

Patient: By signing below, I acknowledge and agree that:

- This proxy request is effective until my Patient Portal account is inactivated, or proxy access is revoked or expires on this specific date: _____
- I will comply with the terms and conditions stated in this document.

X_____ _____
Patient Signature (Required) Date (Required)

Proxy: By signing below, I acknowledge and agree that:

- I will be using my own "Patient Portal" account to access the patient's "Patient Portal" account.
- I will comply with the terms and conditions stated in this document.
- The patient can revoke my access to his/her Patient Portal account at any time.

X_____ _____ _____
Proxy Signature (Required) Relationship to Patient (Required) Date (Required)

ONE PER REQUEST

Health Ministries Clinic
COMMUNITY HEALTH CENTER

Health Ministries Clinic
720 Medical Center Drive
Newton, KS 67114
Tel: (316) 283-6103
Fax: (316) 283-1333

Authorization to Release Protected Health Information

SECTION 1 – Patient Demographics

First Name | Middle Initial | Last Name

Maiden Name or other name used | Date of Birth | Telephone Number

Street Name | City | State | Zip Code

SECTION 2 – Identification of Entity/Persons/ Class of Persons authorized to receive PHI

Release Information FROM:

☐ **Health Ministries Clinic**

Facility:_____

Address | City | State | Zip

Phone | Fax

Release Information TO:

☐ **Health Ministries Clinic**

Facility: _____

Address | City | State | Zip

Phone | Fax

SECTION 3 –Purpose

At the request of the individual the purpose for this disclosure is:

☐ Continuation of Care

☐ Switching Providers

☐ Other: _____

SECTION 4 –Check description of protected health information to be used or disclosed

Most Recent Records (past **18** months)

☐ Colonoscopy
☐ Diabetic Eye Exams
☐ Mammogram
☐ Imaging
☐ Immunizations
☐ Lab Reports
☐ Wellness/Physical exams
☐ Medication List
☐ Other: _____

☐ **ONLY the specified information:** _____

Specify dates of treatment: _____/_____/_____ **to** _____/_____/_____

SECTION 5– Expiration

This authorization shall remain in effect until the date of _____ (or occurrence of a specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. **If left blank, the authorization shall remain effective for 60 days after the date listed below.**

☐ **No** ☐ **Yes, I authorize the release of information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**

☐ **No** ☐ **Yes, I authorize the release of information regarding behavioral or mental health services, and treatment of alcohol and drug abuse.**

SECTION 6 – Statement of Understanding

I, the undersigned, have read the above and authorize the disclosure of such health information as described. I understand that:

- This authorization is voluntary, and I may refuse to sign it.
- Treatment is not conditioned upon the execution of this authorization.
- If the person or entity that receives the information is not a healthcare provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I may revoke this authorization at any time by providing written notice to the person listed as follows by mailing or hand-delivering written notification to the following: Privacy Officer, Health Ministries Clinic, 720 Medical Center Dr., Newton, KS 67114
- If I revoke this authorization, it will not affect disclosures already made in response on this authorization.
- I authorize the use or disclosure of the protected health information (PHI) as described above and may receive a copy of this form.
- Fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $18.97 per request, a copying charge of up to $0.63 for the first 250 pages and $0.45 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine.

_____ _____/_____/_____

Individual or Legal Representative Printed Name | Date

_____ _____ _____

Individual or Legal Representative Signature | Relationship to Patient | Telephone Number

Health Ministries Clinic
COMMUNITY HEALTH CENTER

Health Ministries Clinic
720 Medical Center Drive
Newton, KS 67114
Tel: (316) 283-6103
Fax: (316) 283-1333

Health Ministries Clinic
126 Main St.
Halstead, KS 67056
Tel: (316) 835-3700
Fax: (316) 835-3701

Pine Street Dental Clinic
215 South Pine Street
Newton, KS 67114
Tel: (316) 283-6103
Fax: (316) 283-0543

Self-Declaration of Family Income

Patient Name: _____ Date of Birth: _____

Patient Account Number: _____ Date of Service: _____

Health Ministries Clinic requires each patient who applies for the Sliding Fee Discount Program to declare the number of family members in their household and the family's income. This information is required to determine if the patient qualifies for the Program based on federal government regulations.

Health Ministries Clinic requires the patient to provide proof of family income. Typical documents that fulfill this requirement include the latest IRS tax return, a letter from their employer indicating their take home pay, a paycheck stub, a Social Security Administration letter indicating the amount of their benefit, or a bank statement showing income deposits.

There are circumstances where the patient is unable to provide the required document as proof of income. In those situations, the patient may fill out this form as a self-declaration of family size and income. This signed form by the patient or guarantor is acceptable by Health Ministries Clinic as the family's proof of income.

Family income is defined as taxable income on the IRS tax return or take-home pay on a family member's paycheck stub.

☐ **As the guarantor of the above indicated patient, I hereby self-declare that my family has _____ members who are dependent on our family income. I further self-declare that our family income is $_____ per week, or $_____ every two weeks, or $ _____ per month, or $ _____per year.**

☐ **I waive my right to apply for the Sliding Fee Scale Discount Program for today's healthcare visit. This waiver is effective for one year. I understand that I may revoke this waiver at any time in the future and apply for the Sliding Fee Discount Program.**

I hereby promise that my statement of self-declaration is accurate and truthful.

Patient/Guardian Signature: _____ Date: _____

HMC Employee: _____ Date: _____
Print Name