PATIENT DEMOGRAPHICS

PATIENT INFORMATION

LAST NAME:_____________________________ FIRST NAME:_______________________ MI:_______

SEX:___M ___F DOB:________/__________/__________ RACE:______________________

ADDRESS:____ APT/LOT/TRLR#___________

CITY:___________________________________ STATE:_______________ ZIP CODE:______________

HOME #:(______)________________________ CELL#:(______)________________________

PREFERRED LANGUAGE:____

PREFERRED METHOD OF CONTACT

HM# ☐ CELL# ☐

PREFERRED PHARMACY

PHARMACY NAME: ____

PHARMACY LOCATION: ____

EMERGENCY CONTACT INFORMATION:

NAME:____

RELATIONSHIP:____

PHONE NUMBER: ____

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: ____
(Name of Health Department)

(Hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous written authorization has been given.

DISCLAIMER ON SCREENING: The Department uses screening tests, which are a way to find people who may develop certain common medical problems. Screening tests are valuable because they can find disease early-before it becomes a big health problem. Screening tests do not cover all diseases and may miss some diseases they are supposed to find, so the test results are not final, just one part of a complete exam. Screening tests can alert you to promptly get a medical check-up and treatment from a doctor or health clinic of your choice.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests (which may include HIV testing), give injections, medications, and other treatments, and render other health services to the patient identified on this form.

ADDITIONAL CONSENT: In addition to the above general consent, I understand that special consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's disease, immunizations and family planning methods.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice.

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.

SIGNATURES: Fill blank lines with NA if not applicable.

Patient's Name ____________________________ Patient's Signature___________________________

Person Authorized to Consent (if not patient) ______________________ Relationship______________

Signature ____ Date___________________________

I decline HIV testing at this time. If so, initial here: ______________

SIGNATURES SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name ____

Name of Person Giving Consent ______________________Signature______________________

Relationship to Patient ____ Date_______________

Address ____

Phone Number____

SIGNATURES SECTION III:

Counselor Signature ____ Date_________________

Name/Nombre: ___________________________________

DOB/Fecha de Nacimiento: ________/_______/________

Date/Fecha: _______/________/________

READ & INITIAL EACH POLICY STATING AGREEMENT:

Use and Disclosure of PHI with Other Providers for Continuation of Care

_____I have received the Notice of Privacy Practices and understand that when I receive care at Denton County Public Health personal information about my health, treatment, and payment for services will be received, created, and maintained. I understand that my information will not be used or disclosed without my written authorization (permission) **EXCEPT** as described in the Notice of Privacy Practices that explains that Denton County Public Health may use and disclose my health information without authorization for (i) treatment, (ii) payment, and (iii) healthcare operation purposes. I understand that this includes using and/or sharing my health information with other health care providers that are, and may have been, involved in my care.

Client Responsibilities for Referrals to Specialists

_____ In order to maintain our relationship with specialists, please make sure you keep your appointments. I understand that if I am referred to a specialist, it is my responsibility to keep my appointment. Denton County Public Health will only authorize payment for the initial consultation if I am referred to a specialist. Any testing, procedures, surgeries, or follow-up appointments will be my responsibility. I must contact the office at least 24hrs prior, to reschedule my appointment if I am unable to keep it. The new appointment must be within a two-month period to allow **Denton County Public Health** to make appropriate arrangements for payment. I understand that if I do not call and fail to show up to the appointment, I will be responsible for full payment to the specialist if I make another appointment.

Denton County Public Health Policy on Termination of Services

_____ It is the policy of Denton County Public Health that a client may be terminated if the client is medically noncompliant, disruptive, unruly, threatening, or uncooperative to the extent that the client seriously impairs the staff's ability to provide services or if the client's behavior jeopardizes the safety of themselves, clinic staff, or other clients. Clients will be terminated after their 3rd no-show to their appointments in a year or if there is a pattern of cancelling or rescheduling appointments (5 or more during a year).

Medication Policy

_____ **Beginning January 01, 2014** you will be required to bring all your medications with you to each appointment. Medications include: all prescriptions written by a physician, all over the counter non-prescription medications, vitamins, and supplements. If you do not bring your medications with you, you will be asked to reschedule your appointment.

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION

I understand protected health information (PHI) is information that identifies me. The purpose of this authorization is to allow Denton County Public Health to share my protected health information as defined below.

A. PATIENT INFORMATION

Name: ____ **Date of Birth**: _________________

Preferred method of contact:

( ) Home Phone: ____________________ Leave detailed message: (Yes) ____ (No) ____
( ) Cell Phone: ____________________ Leave detailed message: (Yes) ____ (No) ____
( ) Email: ____

B. EMERGENCY CONTACT INFORMATION

Name: ______________________________________ Phone: _____________________________

Relationship to patient: ____

C. AUTHORIZATION TO SHARE MEDICAL INFORMATION WITH FAMILY AND FRIENDS

In order for us to discuss or disclose any medical information to your family and friends we must have a signed consent on file allowing us to share information about your care. Please list the names of those you would like to involve in your health care. This information can be changed or revoked at anytime with your permission. If you DO NOT want to share any information with others, put N/A.

	Family/Friend Name	Phone Number	Relationship
1.	_______________________________	_____________________	_______________________
2.	_______________________________	_____________________	_______________________

D. INFORMATION TO BE SHARED (Check the boxes of the information you want to share):

☐ **Entire Medical Record** (includes all records except Psychotherapy Notes)

☐ Progress Notes
☐ Cardiology Report(s)
☐ History and Physical
☐ Physician's Orders
☐ Radiology Report(s) & Images
☐ Consultation Report
☐ Laboratory Report(s)
☐ Other: ____________________
☐ Operation Reports
☐ Pathology Reports
☐ Immunizations

Your initials are required to share or release the following information with your family and friends:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse)
_____Genetic Information (including Genetic Test Results)
_____STI Test Results/Treatment
_____TB Test Results/Treatment
_____HIV/AIDS Test Results/Treatment

E. EXPIRATION

When will this authorization expire? (***select one***)

☐ 12 months from date signed ☐ When authorization is withdrawn

☐ Other (specify date or event) ____

F. ACKNOWLEDGEMENT & SIGNATURES

- I understand I may change this authorization at any time by writing to the address listed on this form and that I cannot restrict information that may have already been shared.
- I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.
- I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request.
- I authorize Denton County Public Health to access past RX (prescription) history.

X____ _____________

Signature of Individual (or Personal Representative) **Date**

If signed by a Personal Representative, please specify relationship to the individual**:**

☐ Parent of minor ☐ Guardian ☐ Other _________________________

X____

Printed Name of Personal Representative **(if applicable)**

G. CONSENTING MINOR *(Complete this section ONLY if you are UNDER 18 years of age and the information in this section applies to you. If the information does not apply to you, leave it blank)*

A minor is a person under 18 years of age who has not been married and has never been declared an adult by the court. The Texas law (***Texas Family Code § 32.003 and § 32,004***) allows a minor to consent to treatment and release of medical information when the minor is:

- Under 18 years and on active duty with the armed forces;
- 16 years or older, lives on their own away from their parents, and manages all their financial affairs;
- Unmarried, pregnant, and treatment is related to pregnancy;
- Unmarried and is the parent of a child and has custody of the child;
- Treatment is for drug and chemical addiction or dependency;
- Treatment is for an infectious, contagious, or communicable disease, including screening for sexually transmitted diseases (STD) and HIV, that must be reported by law;
- Counseling is for suicide prevention, chemical addiction or dependency, or for sexual, physical, or emotional abuse.

X____ ___________________

Signature of Consenting Minor Date

X____

Name & Relationship of Individual who helped you fill out this form (if applicable)

Leading our communities to a healthier future.

INFORMED CONSENT TO USE THE DENTON COUNTY PUBLIC HEALTH PATIENT PORTAL

The Patient Portal is a secure, internet-based messaging system that permits you to privately access your medical information and test results maintained by Denton County Public Health (DCPH). The website conforms and complies with the federal law HIPAA (Health Insurance Portability and Accountability). Data is encrypted, which safeguards against any unauthorized use. Only you will have authorized access, using your unique username and password. E-mail addresses, usernames and passwords are never shared by DCPH with other parties.

If you wish to participate in this voluntary service:

1). Read, sign and date this consent form acknowledging you understand and agree to our policy. This must be witnessed and attested to by our staff.
2). Provide us with your written, secure e-mail contact information.
3). You will then receive an e-mail with a unique identification and temporary password, through our electronic medical records vendor *eClinicalworks*.
4). Log in to the Portal website link in the e-mail with your user name and temporary password.
5). Once you are logged in you will have an opportunity to create a new password, and view your test results.

By reading, completing and signing this form I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I Decline Patient Portal Consent ☐

My username and password will not be shared with others, and it is my responsibility to protect these from access by unauthorized persons.

Use of the Denton County Patient Portal System is contingent upon my maintaining satisfactory status as an active patient in DCPH clinics, and this access may be revoked or disabled without prior notification.

To continue patient Portal access, I agree to notify DCPH of any future changes in my e-mail address. I understand that my review and written consent must be updated if/when this policy is modified in the future.

Patient/Guardian Signature:____Date: _____________

Patient name: ____DOB: ______________

Staff Witness:____Date: _____________

Confidential e-mail address (print clearly)____

If the patient is a minor enter name of Parent/Guardian requesting access:

Parent/Guardian: ____Date: ____________

Staff Witness:____Date: ____________