Bluebonnet Trails Community Services

PATIENT REGISTRATION

PATIENT INFORMATION:		
PATIENT NAME (LAST, FIRST, MIDDLE):	DATE OF BIRTH:	TODAYS DATE:

SOCIAL SECURITY NUMBER:	SEX AT BIRTH:
- -	☐ Male ☐ Female ☐ Other
MAILING ADDRESS:	PHYSICAL ADDRESS: (IF DIFFERENT THAN MAILING ADDRESS)
CITY – STATE – ZIP:	CITY – STATE – ZIP:
CELL PHONE:	WORK PHONE:
HOME PHONE:	EMAIL:
PREFERRED METHOD OF COMMUNICATION: ☐ Telephone ☐ Email (healow app) ☐ US Mail ☐ Do Not Leave VM	

INSURANCE INFORMATION: (PLEASE FILL OUT COMPLETELY)

PRIMARY INSURANCE:	ID NUMBER:	GROUP NUMBER:	POLICY HOLDER'S NAME/ DOB:
SECONDARY INSURANCE:	ID NUMBER:	GROUP NUMBER:	POLICY HOLDER'S NAME/ DOB:

PREFERRED LANGUAGE:	☐ English ☐ Español ☐ Other:
MARITAL STATUS:	☐ Single ☐ Married ☐ Widowed ☐ Divorced
ETHNICITY:	☐ Hispanic or Latino ☐ NOT Hispanic or Latino
RACE:	☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska ☐ Native Hawaiian ☐ Other Pacific Islander
ARE YOU LIVING:	☐ Doubled Up (Living with others) ☐ In a homeless Shelter ☐ On the street ☐ Transitional Housing ☐ NOT Homeless
VETERAN STATUS:	☐ Active Duty ☐ Discharged (Veteran) ☐ National Guard ☐ Reserve ☐ None
FARMER STATUS:	☐ Migratory Farm Worker ☐ Seasonal Farm Worker ☐ Not a Farm Worker

Please provide the information requested to help assist Bluebonnet Trails in receiving funding which allows us to provide health care to our communities most vulnerable.

What is your monthly household income: _____ How many people are in your household? (Including yourself) _____

If you choose not to provide this information, please initial here: _____

PARENT/GUARDIAN INFORMATION ONLY FILL OUT IF PATIENT IS A MINOR	
NAME: DOB:	NAME: DOB:
MAILING ADDRESS:	MAILING ADDRESS:
CITY – STATE – ZIP:	CITY – STATE – ZIP:
CELL PHONE:	CELL PHONE:
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:

Emergency Contact Name/ Phone Number/ Relation:

Signature of Patient or Guardian: _____ Date: _____

BLUEBONNET TRAILS COMMUNITY SERVICES
CONSENT TO PRIMARY CARE SERVICES

Name: _____ Date of Birth: _____ Case #: _____

Individual in Services or Legally Authorized Representative (LAR) initial for consent to the left. Write NA for each section not initialed.

_____ Initial Here	**CONSENT TO SERVICES** I hereby consent to care by the Physicians, Physician Assistants, Family Nurse Practitioners, Advance Practice Nurses, and any other Clinical Staff at Bluebonnet Trails Community Services (BTCS) at their service locations. I consent to care encompassing diagnostic procedures, examinations, and treatment. This includes, but is not limited to, lab work, medication administration, and counseling services. I further understand that a mid-level provider (Physician Assistant, Family Nurse Practitioner, or Advance Practice Nurse) is not a licensed physician and may not treat or diagnose any illness, injury, or medical condition except under the supervision and direction of a licensed physician. I further understand that I may revoke this authorization at any time and may request to be seen by a licensed physician or their designated physician replacement. I understand and agree that a provider at BTCS may request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes. I understand that this consent form will be valid and remain in effect as long as I attend BTCS. I have been given an opportunity to ask questions about the services to be provided and I believe that I have sufficient information to give this informed consent.
_____ Initial Here	**COMMUNICATION FOR OPPORTUNITIES TO PARTICIPATE IN IMPROVEMENT OF HEALTHCARE OPERATIONS** I understand that I may be notified by BTCS of opportunities to participate in programs designed to improve quality of care. I understand that participation in these programs is voluntary and will not affect the receipt of services at BTCS. I understand that I may receive notifications of these programs through, but not limited to, the following mediums (phone, mail, email, in person).
_____ Initial Here	**COMMUNICATION WITH BLUEBONNET TRAILS COMMUNITY SERVICES** **YES NO** ☐ ☐ I consent to communications with BTCS via email ☐ ☐ I consent to communication with BTCS via text/SMS ☐ ☐ I consent to communication with BTCS via voice phone call ☐ ☐ I consent to receiving automated reminders
_____ Initial Here	**RECEIPT OF NOTICE OF PRIVACY PRACTICES** I have received a copy of the "HIPAA Notice of Privacy Practices"

_____ Initial Here	**PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION TO HEALTH INFORMATION EXCHANGE** BTCS securely shares data with Health Information Exchanges (HIE) for the purposes of coordination of care, quality improvement of individuals' care, and for statistical analysis. I authorize the release of information to Health Information Exchanges.
_____ Initial Here	**ASSIGNMENT OF BENEFITS** BTCS accepts insurance and I consent for them to bill my insurance and collect any applicable copays, deductibles, and/or coinsurance. I acknowledge that some services offered may not be covered by my specific insurance policy. The fees for those services have been explained to me, and should I choose to participate in these services, **I understand that I am responsible for payment at the time of service and may not be scheduled for my next appointment if I do not make timely payments towards my account balance.** I am responsible for giving accurate information about my current financial status and any changes in my financial status, insurance information, and Medicare or Medicaid eligibility are to be reported at each visit. This information is needed to determine how much to charge and/or bill private insurance, Medicaid, Medicare, or other benefits. If my income is less than the federal poverty guidelines, I may be charged a discounted fee. **It is my responsibility to report all changes after the initial visit and annually BTCS staff will ask for changes at the time of the visit.** I understand that I am required to show recent proof of declination from Medicaid and other local healthcare assistance programs before being placed on the sliding scale. I consent to and authorize BTCS to release medical and supporting documentation to Medicaid, Medicare, or other third-party payers for the purpose of benefit payment.
_____ Initial Here	**Artificial Intelligence (AI)** On occasion, BTCS may utilize AI tools to document your appointment details in the electronic health record. Use of AI allows for your provider to spend more time focusing their attention on you and providing the best care possible. All AI tools are HIPAA compliant meaning your private information remains secure. ☐ **I DO NOT** consent to BTCS utilizing AI tools to document my appointments.

Name of person giving consent, if different from Individual in Services:_____

Relationship to Individual in Services: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other: _____

_____ _____

Signature of Individual in Services/Legal Representative Date

_____ _____

Signature of Staff & Title Date

Bluebonnet Trails Community Services

ADULT HEALTH HISTORY

**NOTE: This information about your healthcare history is confidential, and part of your medical record.*

PATIENT NAME:	DATE OF BIRTH	TODAY'S DATE

Marital Status: (check one)	___ Single ___Married ___ Divorced ___Widowed ___ Domestic Partner			
Occupation:	# of Children	# Of Sexual Partners:	Contraceptive Method Use:	
Use of Alcohol: ___Never ___Socially ___Daily	How many drinks per day:			
Use of Street Drugs: ___ No ___ Yes	If yes, what kind:			
Use of Tobacco: ___ No ___ Yes ___ Quit - If so, how long:	If yes, how many per day:			
Gender Identity: ___ Male ___ Female	___ Transgender Male Female to Male	___ Transgender Female Male to Female	___ Choose Not To Disclose	
Sexual Orientation: ___ Straight	___ Lesbian or Gay	___ Bisexual	___ Something Else	___ Don't Know ___ Choose Not To Disclose
Allergies to Medication(s) or Food(s): ___ No ___ Yes	If yes, please list allergies and reactions below:			
Have you ever had surgery or been hospitalized? ___ No ___ Yes	If yes, please list below:			

SELF MEDICAL HISTORY: CHECK ALL THAT APPLY

ADHD		Depression		GERD		Alcoholism	
Anemia		High Cholesterol		Heart Disease		Osteoporosis	
Anxiety		Headaches/Migraines		Hepatitis/Liver Disease		Seizure Disorder	
Asthma		COPD		Hypertension		Stroke	
Diabetes		Bleeding Disorders		Tuberculosis		Thyroid Disease	
Cancer		What kind:		When:		Other:	

Have you been in the past 12 months or are you currently under the care of another healthcare professional? If yes, please list who below:

FAMILY MEDICAL HISTORY: CHECK ALL THAT APPLY AND LIST FAMILY MEMBERS

M: Mother **MGM:** Maternal Grandmother **PGM:** Paternal Grandmother **PA:** Paternal Aunt **MA:** Maternal Aunt **S:** Sibling
F: Father **MGF:** Maternal Grandfather **PGF:** Paternal Grandfather **PU:** Paternal Uncle **MU:** Maternal Uncle

ADHD		Asthma		Diabetes		Tuberculosis	
Alcoholism		Depression		High Cholesterol		Seizure Disorder	
Alzheimer's Disease		Arthritis		Anxiety		Hypertension	
COPD		Cancer		What Kind:		Other:	

MEDICATION(S) YOU ARE CURRENTLY TAKING:

Name of Medication:	Dosage of Medication:	Provider that prescribed RX:

PHARMACY YOU ARE CURRENTLY USING:

Bluebonnet Trails Community Services

REQUEST AND CONSENT FOR E-MAIL COMMUNICATION

Bluebonnet Trails Community Services

I have requested that Bluebonnet Trails Community Services (BTCS) staff communicate with me (or my Legally Authorized Representative) through e-mail as this is more convenient for me.

Risks common to sending this kind of communication, such as: hackers intercepting these messages, others with access to my computer seeing e-mail communications or attachments that I leave open, unintentional errors in e-mail addresses resulting in information being sent to the wrong person, and the possibility that there will be a longer time lapse before communications of this kind are read, have been explained to me. I am willing to accept these risks.

I also understand that Bluebonnet Trails Community Services will only reply to me (or my family member/caregiver) with encrypted messages, which means I (or they) will have to establish a password when prompted in order to open their response. I (and any family member/caregiver I designate) have been provided the "Guidelines for Use of E-mail Communication" form.

If at any time I wish for staff to stop communicating with me (or my family member/caregiver) in this way, I will so note on this form and alert any members of the staff who are communicating with me by e-mail at that time.

This is the e-mail address I prefer staff use in communicating with me (or my family member/caregiver). I will update the address on this form should it change by marking out the old address, dating and initialing it, and writing the new address next to it.

_____

_____ _____

Printed name of consumer Printed name of parent/guardian

_____ _____

Signature of consumer or legally authorized representative Date

REVISED: 10/2/2020

PATIENT CONSENT FOR TELEMEDICINE AND TELEHEALTH SERVICES

Name: _____ Case #: _____Date:_____

I have been asked by Bluebonnet Trails Community Services (BTCS) to receive telemedicine and/or telehealth services. The purpose is to assess and/or treat my psychiatric and/or other medical condition. I understand this consent applies to all professionals providing telemedicine/telehealth, employed by or contracted with BTCS, and will remain in effect unless revoked. The provision of services is through a two-way audio/video link. I understand that:

1. I, my health care provider, or both of us will talk through the audio/video link with the health care provider

2. If a doctor or nurse is working with me, some parts of a physical exam may be completed. I can ask that the exam and/or audio/video link be stopped at any time.

3. The potential risks and benefits have been discussed with me. I understand these may include (but are not limited to):

Potential Benefits:

- Increased accessibility to mental health care and to specialty services
- Convenience for me

Potential Risks:

- Interruption or disconnection of the audio/video link
- A picture that is not clear enough to meet the needs of the evaluation.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment
- The audio/video link is conducted through the internet. There is a small chance that someone could tap into this session, if security protocols fail.
- A lack of access to all the information that might be available in an in person visit. This could lead to errors in medical decision-making.

4. If any of these risks occur, or if the distant site provider determines there is a reason for me not to participate, then the telemedicine or telehealth service might need to be stopped. If the service is stopped for any reason, the staff at my location will work with me to develop a follow up plan.

5. I authorize the release of any relevant medical information that pertains to me to the health care provider at BTCS, or their agents. This information may include my name, age, birth date, or other information that is necessary to conduct this telemedicine or telehealth service.

6. I understand that this service will become part of my medical record kept by BTCS.

7. I understand that I will not receive any royalties or other compensation for taking part in this service.

8. I understand that I must give my informed consent to participate in this service.

9. I acknowledge that I have received BTCS notice of Privacy Practices, or that I have reviewed the notice on the BTCS website.

10. I know how to contact the Texas Medical Board (1-800-201-9353) if I am seeing a doctor and have a complaint, and understand that this information is also posted on the Bluebonnet Trails Community Services website in the manner required by the Texas Medical Board.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand its contents, and I give my consent to receive telemedicine and telehealth services. This consent remains in effect unless revoked in writing.

Signature of Patient: _____Date:_____

Signature of Witness:_____Date:_____

Or:

The above release is given on behalf of (patient)_____ because the patient is a minor or has been determined unable to give medical consent.

Signature of Parent or Legal Guardian: _____Date: _____

Relationship to Patient: _____

Signature of Witness: _____Date: _____

Bluebonnet Trails Community Services

Partnership Agreement

Welcome to Bluebonnet Trails Community Services (BTCS)! Recovery is at the center of our approach to care. Our goal is to partner with you to meet your health care needs. We strive to exceed expectations and make your experience as comfortable and stress-free as possible.

As partners, we both have rights and responsibilities. Please read this statement and ask any questions you may have.

Human Rights

1) You have a right to be treated with respect and dignity regardless of race, religion, sex, national origin, sexual orientation, political affiliation or ability to pay for services.
2) Our staff also have the right to be treated with dignity and respect.

Payment for Services

1) You are responsible for providing accurate information about your financial status. Please notify us of any changes in your financial status, address, insurance information, and Medicare or Medicaid eligibility. We need this information to decide how much to charge you and/or bill private insurance, Medicaid, Medicare, or other benefits you may be eligible for.
2) We will bill insurance on your behalf; however, you are responsible for all applicable co-pays or deductibles. If for any reason your insurance company does not cover the services received, you will be responsible for payment in full for those services unless you qualify for financial assistance.
3) Not all services are covered by insurance. The following documentation may be requested to determine if you are eligible for financial assistance for non-covered services. For example, if your household income is less than the federal poverty level, you will be charged a discounted fee. You may choose not to provide this documentation; however, you will be billed the full amount for non-covered services.
    - Proof of Income (i.e., Paystubs, benefit verification or award letter)
    - Proof of Residency (i.e., Utility Bill or Letter of Support if living with family or friends)
    - Proof of Major Expenses impacting your income, if applicable (i.e., Payment toward major medical bills, childcare, catastrophic home damage, etc.)
4) If you are eligible for Medicaid, Medicare and/or Medicare Part D benefits, you must apply for these benefits, and we can assist you if you request. If you do not provide proof of application or denial of benefits, you may become responsible for the full cost of your services and medications.
5) If you do not have or are not using insurance, you have the right to receive a Good Faith Estimate explaining how much your medical care will cost. Under the law, health care providers must provide a cost estimate at least one (1) business day before non-emergency services are delivered if your appointment is scheduled in advance. This includes related costs such as medical tests, prescription drugs and equipment. We advise you to save a copy or picture of your Good Faith Estimate. If you receive a bill that is at least $400 more than your estimate, you may dispute the bill. For questions or more information about your right to a Good Faith Estimate, please visit www.cms.gov/nosurprises or call 877-696-6775.
6) You have a right to receive an explanation of your bill. Please call 512-244-8209 if you have any questions.
7) You must pay, or arrange to pay, all applicable fees for services. If you cannot pay right away, please let us know so we can provide care for you now and work out a payment plan.
8) We will not deny services solely based on inability to pay.

Privacy

1) You have a right to receive services in privacy. Your medical records are also private, except in special situations, such as when a judge subpoenas records. Only legally authorized persons may see your records in these circumstances, unless you request in writing for us to share them with someone else. A complete description of your privacy rights is outlined in our *Notice of Privacy Practices.* The Notice details your rights under the Health Insurance Portability and Accountability Act (HIPAA). You should receive the Notice during the intake process, and it is available on our website: www.bbtrails.org/get-help/.

Health Care

1) You are encouraged to participate in decisions about your care, and you are responsible for providing us complete information about your health or illness, so we can give you proper care.
2) You have a right to information and explanations in the language you normally speak and in words you understand. You have a right to information about your health or illness, treatment plan, and expected outcomes, if known, and 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 a legally authorized person upon request.
3) You are responsible for appropriate use of our services, which includes following our staff's instructions, making and keeping scheduled appointments, and arriving to appointments on time. **If you must cancel, please call 1-844-309-6385 at least 24 hours in advance, or the earliest time possible**. If you miss two (2) consecutive appointments, you will be asked to meet with a team member to determine next steps.
4) For your safety and convenience, some services are delivered by televideo or telephone. It is important you download televideo applications in advance, login on time and be prepared to participate in a quiet, well-lit, confidential space free from distractions such as driving, working, and shopping. As our licensed clinicians are licensed to practice in Texas, please know that if you choose to go on vacation out of state when you have a scheduled appointment, we may need to reschedule for when you return. Please let us know your circumstances in advance.
5) You have a right to health care and treatment that is reasonable for your condition and within our capacity to provide. You have a right to be transferred or referred to another facility for services if we are unable to meet your needs. Please note that BTCS does not pay for services you receive elsewhere; however, we are happy to coordinate with your new provider or assist you with sending your medical records.
6) You are responsible for the supervision of children you bring to BTCS, including their safety and the protection of other clients and property.

Complaints

1) If you are not satisfied with our services, please ask to speak with a Program Director. You may also file a complaint with our Client's Rights Officer at any time by calling (512) 244-8324, e-mailing complaints@bbtrails.org, or mailing your complaint to our main office:

Bluebonnet Trails Community Services
Office of Rights Protection/Complaints
1009 N. Georgetown Street
Round Rock, TX 78664

2) If this does not resolve your concern, you may also refer to the *General Public Complaint and Positive Feedback Handout* you received during the intake process to file a complaint with the state office. This is also available on our website: www.bbtrails.org/get-help/. Upon request, we can assist you with filing a complaint. We will never penalize you for filing a complaint, and we will continue to see you as a client during the complaint process if you wish.

3) If you are receiving services in a Rural Health Clinic location, in the event that your complaint remains unresolved with Bluebonnet Trails Community Services, you may file a complaint with our accreditor, The Compliance Team, Inc. via their website www.thecomplianceteam.org or via phone at 1-888-291-5353.

Termination of Services

1) You may choose another provider at any time. We can also decide to stop treating you as a client under certain circumstances with 30 days advance notice. We will provide you with referrals to assist you with finding an alternative health care provider. We can also decide to stop treating you immediately and without notice if we have determined you have created a threat to safety of staff and/or other clients.
2) If we must issue you a notice of termination, you have the right to appeal the decision. Instructions on how to make an appeal will be included in the notice.

I acknowledge I have received a copy of this Partnership Agreement document and understand its contents.

Client Name: _____

Relationship to Client: _____

Client/Guardian Signature: _____ Date: _____

Explained to me by: _____ Date: _____
(Staff Name and Position)