DHCHD
Dallam Hartley Counties Hospital District

DALHART FAMILY MEDICINE CLINIC
206 E. 16th Street, Dalhart TX 79022
P (806) 244-5668 W: dhchd.org

HIGH COUNTRY RURAL HEALTH CLINIC
320 E Texas Blvd., Dalhart, TX 79022
P (806) 244-8324 W; dhchd.org

PATIENT INFORMATION

First and Last Name: _____ Sex: Male / Female

Maiden / Birthname: _____SSN: _____-_____-_____ DOB: _____

Mailing Address: _____ Physical Address: _____

Home Number: _____ Cell Number:_____ Email:_____

Marital Status: Single/ Married/Separated/Divorced/Widowed Hispanic? YES / NO

Race: American Indian/Asian / Black or African American /Native Hawaiian / White

Primary Language: _____

Employer: _____ Employer Number: _____

Appointment Reminds

I wish to be reminded of upcoming appointments via:

☐ HOME PHONE (call) ☐ CELL PHONE (call) ☐ EMAIL ☐ TEXT ☐ PORTAL

Authorization to release medical information

In the event you must be contacted by phone with regards to appointments, test results, referrals, or any other reason, please indicate how you wish to be contacted.

Phone Number: _____ Is it ok to leave a message? Yes No

EMERGENCY CONTACT

Primary-Name: _____ Phone: _____Relation: _____

Secondary-Name: _____ Phone: _____Relation: _____

MINORS ONLY – PARENT OR GUARDIAN

Name: _____DOB: _____ Relationship: _____

Is this patient Guarantor: yes/no If no, who is Guarantor: _____

DOB of Guarantor: _____ SSN of Guarantor: _____

Office Staff Use *Today's Date:*_____ *Given packet to:*_____ *Provider Accepted:*_____

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PATIENT HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

Current Medications: (please include any over the counter medications and/ or supplements)

Medication Name	Strength	Frequency	Medication Name	Strength	Frequency

Preferred Pharmacy: _____

Allergies: (please include all allergies to medications, food, environment, etc.)

_____

_____

_____

Social History:

Tobacco Use: Current: YES NO If yes, how many packs per day? _____How long? _____

Past: YES NO When did you quit? _____ Secondhand exposure? YES NO

Alcohol Use: YES NO If yes, how much / often? _____

Substance Use: ____None ____Marijuana ____Opiates ____Cocaine ____Heroin ____Amphetamines

____Hallucinogens ____Other (please specify): _____

OB/GYN History: (females only)

Age Periods Started: _____ Age Periods Stopped: _____ Last Menstrual Date: _____

Average length of cycle: _____ Average length between periods: _____

Number of Pregnancies: _____ Number of Miscarriages: _____ Number of Live Births: _____

Birth Control Method: _____ Last pap: _____ Last Mammo: _____

The information given in this medical history is accurate to the best of my knowledge.

X_____ _____

Patient Signature (Guardian if minor) Date

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Patient Name: _____ **DOB:** _____

MEDICAL HISTORY

Angina / Chest Pain		GERD (reflux)		Osteoarthritis	
Coronary Artery Disease		Irritable Bowel Syndrome (IBS)		Rheumatoid Arthritis	
Valvular Heart Disease		Crohn's Disease (IBD)		Gout	
Arrhythmias (Afib, WPW, etc.)		Ulcerative Colitis (IBD)		Osteoporosis	
Hypertension		Pancreatitis		Fibromyalgia	
Hyperlipidemia		Peptic Ulcer Disease		Chronic low back pain	
Congestive Heart Failure		Gastritis		Other Chronic Joint Pain: (please specify)	
Abdominal Aneurysm		Hemorrhoids			
History of MI		Chronic Constipation			
Peripheral Vascular Disease		Fecal Incontinence			
Syncope		Hepatitis		Hearing Loss	
		Fatty Liver		Glaucoma	
Diabetes Mellitus		Abnormal Colonoscopy: (please specify		Cataracts	
Hypothyroidism				Vision Loss	
Hyperthyroidism					
				Acne	
Anemia		Headaches		Eczema	
Bleeding Disorder		Stroke (CVA or TIA)		Psoriasis	
Clotting Disorder		Seizures / Epilepsy			
Thrombocytopenia		Peripheral Neuropathy		Chicken Pox	
Deep Vein Thrombosis (DVT)		Restless Leg Syndrome		HIV / AIDS	
Pulmonary Embolism (PE)		Dementia		MRSA	
		Parkinson's Disease		Tuberculosis / Abnormal PPD: (please specify)	
COPD		Multiple Sclerosis (MS)			
Asthma					
Sleep Apnea		Depression		Rubella	
		Anxiety		Polio	
Chronic Kidney Disease		Bipolar Disorder		Mumps	
Urinary Incontinence		Anorexia		Measles	
Kidney Stones		Bulimia		Rheumatic Fever	
Recurrent UTI		Schizophrenic			
Interstitial Cystitis		ADD / ADHD		Cancer: (specify type)	
Hematuria		Autism Spectrum Disorder			
		Learning Delay			
Other: (please specify)					

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Patient Name: _____ **DOB:** _____

Surgical History

(please mark all that apply)

	Date		Date		Date
Tonsillectomy		Cholecystectomy		Mastectomy	
Dental Surgery		Appendectomy		Lumpectomy	
Heart Cath		Splenectomy		Breast Biopsy	
Coronary Stent		Colonoscopy		Skin Cancer Removal	
CABG		Bowel Resection			
Pacemaker / Defibrillator		Hernia Repair		Cesarean Section	
Valve Replacement		Gastric Bypass		Bilateral Tubal Ligation	
Thyroidectomy		Bladder Surgery		Hysterectomy	
Parathyroidectomy		Kidney Surgery		Ovary Removal	
Spine Surgery: (please specify)		Joint Replacement: (please specify)		LEEP	
				D&C	
Other: (please Specify)					

Family History

(please mark all that apply)

	Father	Mother	Sibling(s)	Children	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
Diabetes Mellitus								
Thyroid Disease								
Hypertension								
Hyperlipidemia								
Coronary Artery Disease								
Congestive Heart Failure								
Heart Attack (MI)								
Arrythmia								
Stroke								
Dementia								
Asthma/ COPD								
Bleeding Disorder								
Clotting Disorder								
Autoimmune Disorder								
Depression								
Addiction								
Kidney Disease								
Cancer / Other: (please specify)								

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Patient Name: _____ **DOB:** _____

Epworth Sleepiness Scale

to be scanned to Respiratory Therapy

Please answer the following questions for your provider.

- How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.
- Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.
- Use the following scale to choose the most appropriate number for each situation.

Activity	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.

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PRIMARY INSURANCE

Name of Insurance: _____ Employer: _____

Subscriber Name: _____ DOB: _____ SSN: _____

Relationship: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE

Name of Insurance: _____ Employer: _____

Subscriber Name: _____ DOB: _____ SSN: _____

Relationship: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

Financial responsibility and assignment of benefits: In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/ Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to Dalhart Family Medicine Clinic physicians and/or Medical Practice Income Plan. I authorize direct payments to be made by Medicare/ Medicaid and/or my insurance company or other third-party payers, up to the total amount of my medical and health care charges, to DFMC Physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I hereby give consent to this office to be diagnosed and treated by all qualified medical staff for myself or child. I understand that I have been given the option of seeing any of the above listed upon scheduling an appointment.

NOTICE OF FINANCIAL RESPONSIBILITY

Patient Name: _____ Date of Birth: _____

I have been notified by clinic staff that my insurance may deny payment of certain health care services. If my insurance denies payment, I understand that I will personally and fully be responsible for payment of services rendered. I also understand that I can appeal or discuss such denial of coverage with my insurance company and that covered services may change at any time without notification.

X_____ _____

Patient Signature (Guardian if minor) Date

X_____ _____

Clinic Staff Signature Dat

Office Staff Use *Today's Date:*_____ *Given packet to:*_____ *Provider Accepted:*_____

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DRAFT CHOICE OF LAW AND FORUM CLAUSE

NONEMERGENCY AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering, or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
2. In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall be brought only in a Texas court in the county/ district where all or substantially all the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

X_____ _____

Patient Signature (Guardian if minor) Date

NOTICE OF PRIVACY PRACTICES:

I have asked for and received a paper copy of DFMC Privacy Practices X_____ (Initials)

X_____ _____

Patient Name Date of Birth

X_____ _____

Patient Signature (Guardian if minor) Date

CONSENT TO TREAT

I hereby give consent to this office to be diagnosed and treated by all qualified Medical staff for myself or child. I understand that I have been given the option of seeing any of the above listed upon scheduling an appointment.

X_____ _____

Patient Name Date of Birth

X_____ _____

Patient Signature (Guardian if minor) Date

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize Dalhart Family Medicine Clinic to use and disclose the following information:

____ All Health information

____ Information relating to the following treatment / condition: _____

____My health information covering _____/_____/_____(date) to _____/_____/_____(date)

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, mental health treatment, or HIV/AIDS. Separate consent must be given before this information can be released. I consent to have this separate information released.

_____**YES** _____**NO**

The above party may disclose health information to the following recipient(s):

Name: _____ DOB:_____ Relation:_____

Name: _____ DOB:_____ Relation:_____

Name: _____ DOB:_____ Relation:_____

Name: _____ DOB:_____ Relation:_____

I understand that I have the right to revoke this authorization, in writing, at any time, with the exception where use or disclosures have already been made based upon my original permission. I may not be able to revoke authorization if its purpose were to obtain insurance. To revoke this authorization, I must do so in writing and send it to the HIPAA Privacy Officer.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that I have the right to refuse to sign this authorization.

X_____ _____

Patient Signature (Guardian if minor) Date

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NO SHOW POLICY

Quality care for our patients is our top priority. Please take a few moments to review our "No-Show" Policy.

DEFINITION OF A "NO-SHOW"

Dalhart Family Medicine Clinic defines a "no-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive at the appointment
- Cancels with less than 24 hours' notice.
- Arrives more than 15 minutes late and is consequently unable to be seen

"No-Show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient no-shows an appointment, it:

- Potentially jeopardizes the health of the patient
- Is unfair to the other patients who could have taken the appointment slot
- Disrespects other patient's, clinic staff's, and provider's time

To avoid a "no-show" appointment, arrive 15 minutes early or give the clinic at least 24 hours' notice to cancel an appointment.

The reason we ask you to arrive 15 minutes prior to your scheduled appointment time is to allow our staff to address any insurance or billing questions, update your record in our electronic medical records, and to allow the nurse time to room you and get you prepared to be seen by the provider.

Our staff will attempt to contact you the day before your scheduled appointment to confirm your visit. We must have a correct phone number to reach you. It is your responsibility to keep us updated with any demographic changes. If our facility is unable to confirm your appointment, please contact our office at 806-244-5668 by 9am the business day before the scheduled appointment to make changes.

CONSEQUENCES OF A "NO-SHOW"

A $50.00 fee will be charged for any "no-show" appointment. This policy applies to new and established patients and will be charged directly to the patient/guarantor. THIS WILL NOT BE BILLED TO INSURANCE! **All "no-show" fees MUST be paid prior to the next appointment to be seen.** If you miss 3 appointments within a year, you may be asked to find another provider within 30 days.

I have read and understand the Dalhart Family Medicine Clinic "No-Show" Policy as described above.

X_____ _____
Patient Name Date of Birth

X_____ _____
Patient Signature (Guardian if minor) Date

Office Staff Use *Today's Date:*_____ *Given packet to:*_____ *Provider Accepted:*_____

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FINANCIAL POLICY and ADMINISTRATIVE SERVICES

We are committed to meeting your healthcare needs. Our goal is to keep your insurance and financial arrangements as simple as possible. To accomplish this in a cost-effective manner, we ask you to adhere to the following guidelines and choose a plan that meets your needs:

1. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. **Initial** _____

2. It is your responsibility to confirm with your insurance company that our physicians participate in your insurance plan. **Initial** _____

3. You are ultimately responsible for payment of services you receive from our office at the time of service. Any nonpayment in full, including non-payment of co-pays/coinsurance/deductibles and returned checks will result in a $40 billing fee in addition to the balance owed. **Initial** _____

Attention Patients of New Billing Procedures

In the spirit of respect and transparency, we are informing all our patients about this new billing policy, and we want to be sure that we communicate the expectations clearly, so we have provided very specific details and some examples below.

At Dalhart Family Medicine Clinic and High Country Rural Health Clinic, we strive to provide easy access to our outstanding providers in a timely fashion. To help accomplish this, we leave space on our schedules to accommodate same day visits and walk-ins. We also have a great team of live, on-site operators working hard every day to facilitate appointments and communications.

Most of our providers field dozens of messages per day in addition to seeing and managing scheduled patients. Historically, almost all the clinical time it takes to handle these messages has been free to you and not compensated by insurance companies. However, starting January 1, 2025, you may begin to receive bills for message exchanges that require your provider's clinical time and expertise to answer. Some insurance providers may cover this fee, but it will be your responsibility to check with yours ahead of time to know for sure.

Similar policies have been implemented by many healthcare systems nationally including at the Cleveland Clinic, The University of California San Francisco, and Northwestern Medicine.

It's important to know that not every message you send to your provider will be billed. It's also very important to know that your provider may not feel that managing your issue(s) by messaging is appropriate. In these cases, we can help facilitate an appointment for you.

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Examples of messages that will not be billed:

- Messages that result in an appointment with us within 7 days.
- Asking a question about an issue you saw your provider for in the last 7 days. This does NOT include asking about things that you forgot to mention during your visit or a new issue that has come up since your visit.
- Checking in as a part of your follow-up care after a procedure.
- Giving a quick update to your provider.

Depending on your insurance policy, the cost of most of the applicable messages will be between $30-$60. You could owe closer to $100 for more complex message exchanges requiring at least 20 minutes of your providers' time. In some cases, insurance will cover the costs completely and you will owe nothing.

Examples of messages that may be billed include:

- A new issue or symptom requiring medical assessment, medical decision making or referral **In almost all these cases, we strongly encourage (and may even require) a scheduled appointment. You should call 911 in an emergency or be taken to a hospital. **
- Medication management including dose adjustments, changes that you make to your pharmacy, emergency refills and short-term (30 days or less) refills when you're due for a follow up visit.
- Chronic disease check-in and management
- Flare-up or change in chronic condition

We are grateful to all of you who trust us with your healthcare. We believe that this new policy will help us to continue providing the highest level of care and service that sets us apart. Please let us know if you have any questions regarding this policy. Additionally, if you are interested in checking on the specifics of this with your insurance company, the CPT codes currently in use for this are 99421, 99422 and 99423.

Acknowledgement signature: _____ Date: _____

Office Staff Use *Today's Date:*_____ *Given packet to:*_____ *Provider Accepted:*_____

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AUTHORIZATION FOR RELEASE INFORMATION

(THIS MUST BE FILLED OUT COMPLETELY)

Patient Name: _____DOB: _____

SS#: _____Address: _____

I authorize DALHART FAMILY MEDICINE CLINIC to disclose my individual health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes) chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal and state privacy regulations, I understand that mt Health care and the payment of my Health Care will not be affected if I do not sign this from.

Information To Be Released To:

DALHART FAMILY MEDICINE CLINIC
PO BOX 1208/ 206 EAST 16TH ST
DALHART, TEXAS 79022
Fax:
Phone: 806-244-5668

FROM:

_____
_____
_____
_____

(IF MORE THAN 30 PAGES PLEASE DO NOT FAX)

Information to be released (check all that apply)

__History/Physical exam notes
Dates: _____

_____

__Laboratory Reports
Dates: _____

__X-Ray Reports
Dates: _____

__Other Diagnostic Reports
Dates:

__Other (please specify)
_____
_____

Reason or Purpose for Release (check the appropriate category)

__Continue Patient Care
__Attorney Legal
__Insurance Claim Application
__Personal Use
__Other_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patients is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 180 days after the day of my signature unless otherwise specified.

X_____ _____

Patient Signature (Guardian if minor) Date

PATIENT PORTAL INFORMED CONSENT

Office Staff Use *Today's Date:*_____ *Given packet to:*_____ *Provider Accepted:*_____

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Name: _____ DOB: _____E-Mail Address: _____

PURPOSE OF THIS FORM

Dallam Hartley County Hospital District offers secure viewing of parts of your medical record and communication from our staff as a service to our patients. Secure messaging can be a valuable communications tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that; you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation. This service is optional and not necessary to interact and communicate with our clinic.

HOW THE SECURE PATIENT PORTAL WORKS

A secure Web portal is a kind of webpage that uses encryption to keep unauthorized person from reading communications, information, or attachments. Secure messages and information can only be ready by someone who knows the right password to log into the portal site.

HOW TO PARTICIPATE IN OUR PATIENT PORTAL

You can pick up secure message or view information sent to you through a website. Once this form is agreed to and signed, we will send you an e-mail notification that tells you how to register for the first time. This notification will give you the URL (Internet address) of the website where you can log in using the username and password provided. Next you will be able to look in your message box and see any new or old messages or view other parts of your electronic medical record. You can read or view information on your computer, but it is still encrypted in transmission between the website and your computer. You can view more clinic specific information or access the Patient Portal through our clinic web page: https://dhchd.org

PROTECTING YOUR PRIVATE HEALTH INFORMATION AND RISKS

This encrypted method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. When you pick up secure messages from the portal, you need to keep unauthorized individuals from learning your password and gaining access to your account. If you think someone has learned your password, you should promptly go to the website and change it. You need to make sure we have your correct e-mail address and are informed if it ever changes. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible and will never sell or give away any private information, including e-mail addresses.

CONDITIONS OF PARTICIPATING IN THE PATIENT PORTAL

Access to the secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate the service, we will notify you as promptly as we reasonably can. You agree to not hold Dallam Hartley County Hospital District or any of its staff liable for network infractions beyond their control.

Patient Acknowledgement: _____Date: _____

Office Staff Use *Today's Date:*_____ *Given packet to:*_____ *Provider Accepted:*_____