ISLAMIC ASSOCIATION OF CARROLLTON (MASJID AL-RAHMAN) MEDICAL CLINIC

UNIVERSAL CONSENT FOR TREATMENT

I understand that my/my child(ren) health condition requires outpatient care. I consent to and authorize testing, treatment and/or hospital care as ordered by the doctor and his/her consultants, associates and assistants. I authorize Clinic nurses, employees, volunteers and others as necessary to carry out the instructions of doctor(s) with respect to the procedures and treatment they have ordered. I understand that it may be necessary for representatives of outside health care companies to assist in my/my child(ren) care. I also understand student nurses and others in professional training programs and volunteers may be among the individuals who provide care to me/my child(ren). I understand that in connection with my/my child(ren) treatment, photos or videos may be taken. Any tissue or body parts removed from my/my child(ren) body may be retained or disposed of by the Clinic at its sole discretion.

I also understand and acknowledge that Texas law provides if any health care worker is exposed to my/my child (ren) blood or other bodily fluid, the Clinic may perform tests, with or without my consent, on my/my child(ren) blood or other bodily fluid to determine the presence *of* any communicable disease, including but not limited to, Hepatitis, HIV/AIDS and Syphilis. **I** understand that such testing is necessary to protect those who will be caring for me/my child(ren) while I am a patient of the Clinic. I understand that the results of tests taken under these circumstances are confidential and do not become a part of my/my child(ren) medical record.

I acknowledge and agree that the doctors participating in my/my child(ren) care in the Clinic do not work for the Clinic. They are not employees, servants or agents of the Clinic. They are either engaged in the *private* practice of medicine or are licensed practitioners participating in the care of patients. I acknowledge and agree that the Clinic is not responsible for the judgment or conduct of any doctor who treats or provides a professional service to me/my child(ren).

CHARITY CARE: I acknowledge and agree that the doctor(s) participating in my/my child (ren) care in this Clinic is/are a volunteer health care professional(s) and is not administering care for or in expectation of compensation. I also understand that as a volunteer health care professional the physician(s) is/are immune from civil liability for any act or omission resulting in death, damage or injury as long as the volunteer acts in good faith and in the scope of his or her duties within the organization in providing health care services.

NO GUARANTEE: I acknowledge that no guarantees or warranties have been made with respect to treatment to be provided at this Clinic to me/my child(ren).

If the person signing this form **is not the** patient, please give full name, phone number and address:

_____

_____

I HAVE READ AND UNDERSTAND THIS INFORMATION.

Signature of Patient, Parent/Guardian or Legally Authorized Representative	Relationship to Patient	Reason Patient unable to Sign
Witness	Title	Date of Signature

NOTICE OF PRIVACY PRACTICES*

ISLAMIC ASSOCIATION OF CARROLLTON (MASJID AL-RAHMAN) MEDICAL CLINIC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT. PLEASE REVIEW IT CAREFULLY.

How we handle your health information: We may use and disclose your health information. We use health information about you for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health Information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health Information. If you sign an authorization to disclose Information, you can later revoke it to stop any future uses and disclosures.

Your rights: In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your Information that we have made, if you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

Our legal duty: We are required by law to protect the privacy of your health Information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more Information about our privacy policies, contact us.

Privacy complaints: If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health Information, you may contact the clinic director. You also may send a written complaint to the U.S. Department of Health and Human Services.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have had this Notice of Privacy Practices made available to you. Please sign this acknowledgement where indicated below and return it to the clinic staff.

Patient Health Information Designee (PHI): All information about is confidential and will not be released to anyone unless you have assigned him or her as PHI designee.

Name	Signature	Date of Signature
PHI Designee	Signature	Date of Signature

*The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

ISLAMIC ASSOCIATION OF CARROLLTON (MASJID AL-RAHMAN) MEDICAL CLINIC

SCREENING QUESTIONS TO DETERMINE YOUR ELIGIBILITY FOR FREE HEALTH CARE

Following questions will be used by the receptionist to determine the eligibility of patients for the fee healthcare at our clinic.

Question	Yes	No
I am unable to afford routine medical care for myself or my children.		
My/my child's condition does not require any urgent/emergent care.		
I/my child am/is not a current patient of the IANT Medical Clinic, EPIC Medical Clinic or West Plano Masjid Clinic.		
I/my child am/is not visiting the clinic to solicit a second opinion of already exciting condition(s).		
I agree to pay for any lab work or other investigational studies as deemed appropriate by the treating physician.		
I understand that if the clinic staff determines that I am able to pay for my/my child's visit and do not meet the eligibility criteria; then the clinic reserves the right to ask for last 2 years of my Federal income tax returns and or decline to provide me/my child charity care.		
I certify that my annual household income is below the 2013 poverty guidelines. I have attached last year's tax return.		

2013 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline
1	$11,490
2	15,510
3	19,530
4	23,550
5	27,570
6	31,590
7	35,610
8	39,630
For families/households with more than 8 persons, add $4,020 for each additional person.	

http://aspe.hhs.gov/poverty/13poverty.cfm

ISLAMIC ASSOCIATION OF CARROLLTON (MASJID AL-RAHMAN) MEDICAL CLINIC

SCREENING QUESTIONS TO DETERMINE YOUR ELIGIBILITY FOR FREE HEALTH CARE

Name:			DOB:
Address:	City:	State:	Zip:
Mobile Phone:	Home Phone:		
Email:	SS No:		
Driver License:			State:
Occupation:	Best time to contact you:		
PHI Designee Information: Do you want to you assigned a PHI designee?			Yes No
Name:		Relationship:	
Address:	City:	State:	Zip:
Mobile Phone:	Home Phone:		
Email:	SS No:		
Past Medical and Surgical History:			
Allergies:			
Current Medications:			
Notes:			