WOVEN HEALTH
integrated community healthcare

Woven Health Clinic
Patient-Centered Medical Home

WHAT IS A PATIENT-CENTERED MEDICAL HOME?

A patient-centered medical home is a system of care in which a team of health professionals' work together to provide all of your health care needs.

You, the patient, are the most important part of a patient-centered medical home. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need.

WHO IS ON THE PATIENT-CENTERED MEDICAL HOME CARE TEAM?

Your primary care doctor leads your care team, which may include other doctors, nurses, medical assistants, health educators, and other health care professionals. Our team acts as "coaches" who help you get healthy, stay healthy, and get the care and services that are right for you. You, of course, are at the center of your care team. .

HOW DO YOU GET THE MOST FROM A PATIENT-CENTERED MEDICAL HOME?

WHAT YOU CAN DO:

BE IN CHARGE OF YOUR HEALTH

- Know that you are a full partner in your care.
- Understand your health situation and ask questions about your care.
- Learn about your condition and what you can do to stay as healthy as possible.

PARTICIPATE IN YOUR CARE

- Follow the plan that you and we have agreed is best for your health.
- Take medications as prescribed.
- Keep scheduled appointments and attend follow-up visits.

COMMUNICATE WITH YOUR CARE TEAM

- Tell us when you don't understand something we said or ask us to explain it in a different way.
- Tell us if you get care from other health professionals so we can help
- Bring a list of questions and a list of medicines or herbal supplements you take to every appointment.
- Tell us about any changes in your health or well-being.

WHAT WE WILL DO:

GET TO KNOW YOU

- Learn about you, your family, your life situation, and likes and dislikes. We will update your records every time you seek care and suggest treatments that work for you.
- Listen to your questions and feelings and treat you as a full partner in your care.

COMMUNICATE WITH YOU

- Explain your health situation clearly and ensure you know all your options for care.
- Give you time to ask questions and answer them in a way you understand.
- Help you make the best decisions for your care.

SUPPORT YOU

- Help you set goals for your care and help you meet these goals every step of the way.
- Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy.
- Treat you with dignity and compassion.

HOW DOES A PATIENT-CENTERED MEDICAL HOME BENEFIT ME?

You can communicate with us easily and efficiently and get appointments quickly, sometimes the same day you call.

We know you and your health history. We know about your personal or family situation and can suggest treatment options that make sense for you.

We help you understand your condition(s) and how to take care of yourself. We explain your options and help you make decisions about your care. For resources to manage your conditions, please visit our Youtube:

www.youtube.com/wovenhealthclinic

We help you manage your health care – even if we are not the ones giving you the care. We will help you with referrals, get appointments when possible and make sure other providers have the information they need to care for you. To reach the clinic after hours, please call the clinic and select 5.

Patient Name _____ **Patient Signature** _____ **Date** _____

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SERVICE FEES | TARIFAS DE SERVICIO

Service | Servicio	Fees | Tarifas
Primary Visits Visitas Primarias	$30 $30 Ear Lavage/ Lavado de oídos
GYN GINECÓLOGO	$30 Visit Fee / Tarifa de visita + $65 Pap Smear / Prueba de Papanicolaou $50 NuSwab $50 IUD Removal / Extracción del DIU $20 Depo Injection / Inyección de Depo $20 Pregnancy Test
Specialty Clinic (Derm & Neuro) Clínica de Especialidades (Derm y Neuro)	$30
Supplies Suministros	$20 Glucometer Kit / Kit de glucómetro $10 Glucometer (Single Meter) / Glúmetro (medidor único) $5 Lancing Device (Single Device) / Dispositivo de punción $6 Test Strips / Tiras reactivas $2 Alcohol Pads / Almohadillas con alcohol $1 Lancets (box of 50) / Lancetas (Caja de 50)
Replacement Copies (Labs/ Imaging Orders) Copias de reemplazo (laboratorios, pedidos de imágenes)	$10 Per additional copy. Copy obtained during visit is no cost. / Por copia adicional. La copia obtenida durante la visita no tiene costo.

Woven Health Clinic service fees are subject to change at any time without notice. If you are enrolled in Woven Health's Direct Primary Care Program, please contact our program coordinator with any questions regarding what may be covered by your membership fees.

Las tarifas de servicio de Woven Health Clinic están sujetas a cambios en cualquier momento sin previo aviso. Si está inscrito en el Programa de Atención Primaria Directa de Woven Health, comuníquese con nuestro coordinador del programa si tiene alguna pregunta sobre lo que puede estar cubierto por sus tarifas de membresía.

Signature:_____ Date:_____

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integrated community healthcare

Discounted Labs Patient Agreement

As a patient of Woven Health Clinic, I understand that I am offered extremely discounted low-cost lab work. In order to receive these heavily discounted rates, I understand that it is my responsibility to pay any lab fees directly to Woven Health Clinic, the day of my appointment.

____I understand that if I do not pay for the labs the day of my appointment, I will need to book another appointment to have my lab work ordered.

____I understand that if I choose not to pay lab fees directly to Woven Health Clinic, I will be responsible for any bill I receive from LabCorp.

____I understand that I will not be given a refund for any labs I do not get.

Acuerdo del Paciente de Laboratorios con Descuento

Como paciente de Woven Health Clinic, entiendo que se me ofrece un trabajo de laboratorio de bajo costo con un descuento extremo. Para recibir estas tarifas con grandes descuentos, entiendo que es mi responsabilidad pagar cualquier tarifa de laboratorio directamente a Woven Health Clinic, el día de mi cita.

____Entiendo que si no pago los análisis de laboratorio el día de mi cita, tendré que programar otra cita para que me ordenen los análisis de laboratorio.

____Entiendo que si elijo no pagar las tarifas de laboratorio directamente a Woven Health Clinic, seré responsable de cualquier factura que reciba de LabCorp.

____Entiendo que no se me dará un reembolso por ningún laboratorio que no reciba.

I have read the patient's responsibilities for receiving heavily discounted low-cost labs and I agree to the terms and conditions.

He leído las responsabilidades del paciente para recibir laboratorios de bajo costo con grandes descuentos y acepto los términos y condiciones.

Sign/Firmar:_____ Date/Fecha:_____

WOVEN HEALTH® CLINIC
integrated community healthcare

No Show Policy

At Woven Health Clinic, we value every patient's time and the resources invested in providing quality care. It is essential for patients to honor their appointments to ensure efficient operation and equitable access to our services for all.

Policy Overview:

If a patient is a no-show at two scheduled appointments within a six-month period without prior notice, they will be required to prepay for their visit before rescheduling any future appointments.

If a patient is a no-show for three scheduled appointments within a 12-month period without prior notice, they will be at risk of being discharged from the clinic.

Importance of Appointment Attendance:

Keeping appointments is crucial for the effective functioning of our clinic and ensuring that all patients receive timely care. When patients do not show up for their appointments, they not only disrupt our scheduling but also deprive other individuals of the opportunity to receive necessary medical attention.

We understand that unforeseen circumstances may arise, and we encourage patients to notify us as soon as possible if they are unable to attend their appointment. A no-show fee of $25 may be applied if your appointment is missed or cancelled less than 48 hours in advance. By working together, we can ensure that our clinic operates smoothly and continues to serve the community effectively.

By scheduling an appointment with Woven Health Clinic, patients agree to adhere to the No Show Policy outlined above.

Your health is important to us, as a medical home, we strive to provide you with the most effective treatment plan. Failure to comply with clinic guidelines, required lab work, and treatment recommendations can result in being discharged as a patient from Woven Health Clinic, as this prevents us from providing the highest quality care possible.

Patient Signature: _____ Date_____

1 MEDICAL PARKWAY, PLAZA 1, SUITE 149,
FARMERS BRANCH, TX 75234

CONSENT TO TREATMENT BY VOLUNTEERS
I understand that services I receive may be provided by volunteers that are not administered for or in expectation of compensation.

I FURTHER UNDERSTAND THAT TEXAS LAW IMPOSES LIMITATIONS ON THE RECOVERY OF DAMAGES FROM SUCH A VOLUNTEER IN EXCHANGE FOR RECEIVING HEALTH CARE SERVICES UNDER TEXAS CIVIL PRACTICE AND REMEDIES CODE, CHAPTER 84, ENTITLED "CHARITABLE IMMUNITY AND LIABILITY," SECTIONS 84.001-84.004. HEALTH CARE SERVICES ARE RENDERED BY VOLUNTEERS WHO ARE LICENSED TO PRACTICE MEDICINE UNDER THE MEDICAL PRACTICE ACT (ARTICLE4495B VERNON'S TEXAS CIVIL STATUTES).

Those limitations include immunity from civil liability for any act or omission resulting in death, or injury to a patient if:

(1) The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization;
(2) The volunteer commits the act or omission in the course of providing health care services to the patient;
(3) The services provided are within the scope of the license of the volunteer; and,
(4) Before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges:
(a) that the volunteer is providing care that is not administered for or in expectation of compensation; and,
(b) The limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

DISCLAIMER

- Fees collected in conjunction with health care services provided by this clinic are strictly reserved for administrative costs of the clinic and do not represent compensation to volunteering licensed individuals providing health care service.
- Health care services are rendered by volunteers who are licensed to practice medicine under the Medical Practice Act (Article4495b Vernon's Texas Civil Statutes).
- Individuals covered by the Act include: physicians, physician assistants, registered nurses and licensed vocational nurses.
- Volunteers provide care that is not administered for, or in expectation of, compensation.
- The clinic abides by the statutorily mandated liability insurance requirements as set forth under the Charitable Immunities Act of 1987

I HAVE READ AND UNDERSTAND THE ABOVE AND CHOOSE TO BE TREATED BY A VOLUNTEER, UNDERSTANDING THE LIMITATIONS ON THE RECOVERY OF DAMAGES DESCRIBED ABOVE FOR:

_____	_____	_____
Printed Name of Patient	**Patient's Signature**	**Date**

Health Insurance Portability and Accountability Act of 1996 (HIPAA) CONSENT

I understand that I have certain rights to privacy regarding my Protected Health

Information. These rights are given to me under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

I understand that by signing this consent I authorize you to use and disclose my Protected Health Information in order to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers and volunteers involved in my treatment) at Woven Health Clinic (the "Clinic") and
- In the payment of healthcare and
- In the day-to-day healthcare operations of the Clinic.

I understand that the sharing of information concerning my condition or treatment as recorded in documents generated at the Clinic may be used in the processing of medical referrals and in collaborating with medical facilities to which I have been referred for consultation or treatment.

I understand that documents regarding my medical records may be transferred from a referring facility, which will also treat these documents with equal privacy and protection.

I understand that these documents may not be shared with another treatment entity without my specific written consent.

I have also been informed of and given the right to review and secure a copy of the Clinic's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my Protected Health Information and my rights under HIPAA.

I understand that the Clinic reserves the right to change the terms of this notice from time to time and that I may contact the Clinic at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my Protected Health Information is used and disclosed to carry out treatment, and for payment and health care operations, but that the Clinic is not required to agree to these requested restrictions. However, if the Clinic does agree, the Clinic is then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____	_____	_____
Printed Name of Patient	**Patient's Signature**	**Date**

WOVEN HEALTH® CLINIC
integrated community healthcare

PATIENT INTAKE FORMS | FORMULARIOS DE ADMISIÓN DE PACIENTES

Date (Fecha):_____ **Name (Nombre):**_____

Preferred Language (Idioma Preferido): ☐ **English** ☐ **Espanol** ☐ **Other/Otra:** _____

Sex (Sexo): ☐ **Male (Masculino)** ☐ **Female (Femenino)** **D.O.B (Fecha de Nacimiento):**_____

Social Security Number (Número de Seguro Social): _____ /_____/_____

Primary Phone (Numero de Contacto Principal):_____

Secondary Phone (Numero de Contacto Secundario):_____

Email (Correo Electronico):_____

Address (Direccion):_____ **Apt# (Apartamento):** _____

City (Ciudad):_____ **State (Estado):**_____ **Zip (Codigo Postal):**_____

County (Condado):_____

Ethnicity (Etnia): ☐ **Hispanic/Latino or Spanish Origin** ☐ ***Not*** **Hispanic/ Latino or Spanish**

Origin Race (Raza):

- ☐ **White (Blanco)**
- ☐ **Black or African American (Negro o Afroamericano)**
- ☐ **Asian (Asiatico)**
- ☐ **American Indian or Pacific Islander (Indios americanos o isleños del Pacífico)**
- ☐ **Other:** _____

Emergency Contact/ Contacto de Emergencia:

Name/Nombre:_____ **Phone/Telefono:**_____

Relationship/Relación:_____

How did you hear about Woven Health Clinic/ ¿Cómo te enteraste de Woven Health Clinic?

- ☐ **Online Search/ Búsqueda en línea**
- ☐ **From Family/ Friend / Familia/Amigo**
- ☐ **Metrocrest Services**
- ☐ **Health Fair / Feria de la Salud**
- ☐ **Other/ Otro:**_____

WOVEN HEALTH® CLINIC

MEDICAL HISTORY QUESTIONNAIRE | CUESTIONARIO DE HISTORIA CLÍNICA

Are you disabled? (Esta incapacitado?) ☐**Yes (Si)** ☐**No**

Are you on blood thinners? (Esta tomando anticoagulantes?) ☐**Yes (Si)** ☐**No**

Are you taking any controlled substances?(Esta tomando sustancias controladas?) ☐**Yes (Si)** ☐**No**

Have you ever had chicken pox? (Alguna ves ha tenido varicela?) ☐**Yes (Si)** ☐**No**

Has it been more than 10 years since your last tetanus vaccine? (Han pasado mas de 10 anos desde su ultima vacuna contra el tetano?) ☐**Yes (Si)** ☐**No**

Have you ever been diagnosed with Bipolar disorder or Schizophrenia? (Alguna vez le han diagnosticado trastorno Bipolar o Esquizofrenia?) ☐**Yes (Si)** ☐**No**

Have you ever been diagnosed with any of the following conditions? Select all that apply. (¿Alguna vez le han diagnosticado alguna de las siguientes condiciones? Seleccione todas las que correspondan.)

- ☐ Diabetes (Diabetes)
- ☐ High Cholesterol (Colesterol Alto)
- ☐ Hypothyroidism (Hipotiroidismo)
- ☐ Heart Problems (Problemas del Corazon)
- ☐ Seizures (Convulsiones)
- ☐ High Blood Pressure (Presion Alta)
- ☐ Pneumonia (Neumonia)
- ☐ Asthma (Asma)
- ☐ Kidney Disease (Enfermedad del Rinon)
- ☐ Anemia (Anemia)
- ☐ Hepatitis (Hepatitis)
- ☐ Liver Problems (Problemas de higado)
- ☐ Stomach Ulcers (ulveras Estomacales)
- ☐ Skin Disorders (Trastornos de la Piel)
- ☐ Cancer (Cancer):_____
- ☐ Other (Otro) : _____

_____

_____

List all past surgeries (Liste todas las cirugias pasadas): _____

_____

Are you allergic to any medications? (Eres alérgico a algún medicamento?) ☐**Yes (Si)** ☐**No**

If Yes, to what? (En caso afirmativo, ¿a qué?):_____

Please list any medication you are currently taking. Include over the counter and/or vitamin supplements. (Liste cualquier medicamento que este tomado ahora. Incluya medicamentos sin receta y vitaminas o suplementos.)

Name of Drug (Nombre de la droga)	Dose (Including how many per day) Dosis (Incluya la cantidad de pildoras por dia)	How long have you been taking this? (Cuanto tiempo ha estado tomando esto)

WOVEN HEALTH® CLINIC

Sharing your income information helps us connect you with programs and services you may be eligible for, and also supports the clinic in securing grants and funding. Please note that providing this information will not affect your ability to receive care at our clinic.
Compartir información sobre sus ingresos nos permite conectarlo con programas y servicios para los que podría calificar, y también ayuda a la clínica a obtener subvenciones y financiamiento. Tenga en cuenta que proporcionar esta información no afectará su acceso a los servicios en nuestra clínica

Patient Information / Información del Paciente

- Name/ Nombre:_____
- Phone / Telefono: _____
- Date of Birth/ Fecha de Nacimiento: _____

___Single/Soltero ___Married/ Casado ___Divorced/Divorciado __Widow/ viuda __Separated/Separado

Household Information / Información del Hogar

- Total number of people in your household / Número de personas en el hogar: _____
- If **SINGLE,** are you the Head of Household? / • Si es **SOLTERO**, ¿es usted el jefe de familia? ___Yes ___No

Source of Income / Fuente de Ingresos

- ☐ Employment / Empleo
- ☐ Social Security / Seguro Social
- ☐ Disability / Discapacidad
- ☐ Unemployment / Desempleo
- ☐ Other / Otro: _____

Self-Certification / Autocertificación

- ☐ I am currently unemployed and have no income / Actualmente estoy desempleado y no tengo ingresos
- ☐ I am currently living with someone who provides for my basic needs / Actualmente vivo con alguien que cubre mis necesidades básicas
- ☐ I am a day-laborer or work odd jobs for cash/ Soy un jornalero o tengo trabajos ocasionales por dinero en efectivo

Monthly Income Table / Tabla de Ingresos Mensuales

(Include information for each working member of your household / Incluya información de cada miembro trabajador de su hogar.)

Name/Nombre	$ Weekly/seminal $ Bi-Weekly/quincenal	$ Monthly/ Total por Mes	$ Annual Total/ Total Anual

Documentation Requirements / Requisitos de Documentación

- - Photo ID / Identificación con foto
- - Proof of address (utility bill, lease, etc.) / Prueba de dirección (factura de servicios, contrato de arrendamiento, etc.)

Signature/ Firma:_____ Date/Fecha:_____

WOVEN HEALTH® CLINIC
integrated community healthcare

RESIDENCY VERIFICATION | VERIFICACIÓN DE DOMICILIO

The following are acceptable documentation to verify your address – Only <u>one</u> is required, unless otherwise stated (Lo siguiente es documentación aceptable para verificar su dirección: solo se requiere una, a menos que se indique lo contrario):

- Valid TX Drivers License or State ID Card (Licencia de conducir válido de TX o tarjeta de identificación estatal)
- Utility or Phone bill or records (Factura o registros de servicios públicos o teléfono)
- Rent Receipt or Statement from **non-relative** landlord (Recibo de alquiler o estado de cuenta del arrendador que no es pariente)
- Mortgage receipt or statement from Mortgage company (Recibo de hipoteca o estado de cuenta de la compañía hipotecaria)
- DMV Records (Registros del DMV)
- School Records (Registros escolares)
- Voter Registration Card (Tarjeta de Registro de Votante)
- Child Care Provider Statement (Declaración del proveedor de cuidado infantil)
- Employment Records or Statement (Registros o Declaración de Empleo)
- Official records confirming ownership of property (Registros oficiales que confirmen que es propietario de la propiedad)
- Church Records (Registros de la iglesia**)**
- Notarized statement from an individual with at least one of the above listed items in their name, attesting that patient is living at their address (Declaración notariada de una persona con al menos uno de los documentos anteriores a su nombre, que atestigüe que el paciente vive en su residencia)
- Matricula Consular with household name and address (Matrícula Consular con nombre y dirección)
- **<u>TWO</u>** items of mail with household name and address (DOS cartas de correo con el nombre y la dirección del hogar)

Woven Health Clinic is a charitable medical clinic, which provides medical care to the uninsured residents of our community. In order to provide services and plan for our future, the requested information must be collected on a regular basis. This information is protected by the Health Information and Portability Act and cannot be shared without your permission. If we are unable to gather this information from our patients, we we reserve the right to deny services to that individual. To participate in some programs, you may be asked to provide documentation of your financial and/or residential situation.

Woven Health Clinic es una clínica médica caritativa que brinda atención médica a los residentes sin seguro de nuestra comunidad. Para brindar servicios y planificar nuestro futuro, la información solicitada debe recopilarse de forma regular. Esta información está protegida por la Ley de Portabilidad e Información de Salud y no puede compartirse sin su permiso. Si no podemos recopilar esta información de nuestros pacientes, nos reservamos el derecho de negarle servicios a esa persona. Para participar en algunos programas, es posible que se le solicite que proporcione documentación de su situación financiera y/o residencial.

WOVEN HEALTH® CLINIC
integrated community healthcare

Patient Consent for Release of Protected Health Information (PHI)

Many of our patients allow family members such as their spouse, parents, or others to call & request test results/procedures, appointments & prescription/sample pick up. Under the requirements of HIPPA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your protected health information (PHI) release to anyone other than yourself, you must complete this form. This form will expire by written notification from you ONLY.

I,_____ , give my consent to the Woven Health Clinic to release protected health information (PHI) such as labs. medications. prescriptions, samples, appointments, provider's notes, etc. to the following individuals in person or via telephone.

Name	Relationship	Phone # (if different from patient)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorization to leave personal health information by alternate means

Please check all that apply: **(detailed messages may include lab/test results)**

- ☐ May leave detailed message on voicemail at home#: _____
- ☐ May leave detailed message on mobile phone#: _____
- ☐ May leave detailed message on voicemail at work#: _____
- ☐ May leave information with spouse (name): _____
- ☐ May leave information with other family member (name): _____
- ☐ Do NOT leave any detailed message on any phone. _____
- ☐ May leave information **ONLY** about appointment reminders. _____

_____	_____
Patient Name (please print)	Date
_____	_____
Patient Name (signature)	Date

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integrated community healthcare

MEDICAL RECORDS RELEASE FORM | FORMULARIO DE DIVULGACIÓN DE EXPEDIENTES MÉDICOS

I do hereby consent and authorize Woven Health Clinic to release copies of my medical records.
Por la presente doy mi consentimiento y autorizo a Woven Health Clinic a divulgar copias de mis registros médicos.

Patient Name (Nombre):_____ DOB:_____

Phone Number (Número de teléfono):_____

Address (Direccion):_____

City (Ciudad) State (Estado) Zip (Codigo Postal):_____

Records requested to/from Woven Health Clinic (Registros solicitados hacia/desde Woven Health Clinic)

Facility Name (Nombre de la instalación):_____

Address (Direccion):_____

City (Ciudad) State (Estado) Zip (Codigo Postal):_____

Phone Number (Número de teléfono):_____

Email (Correo electrónico):_____ Fax: _____

Please select all of the specific documents that apply to this request:
Seleccione todos los documentos específicos que se aplican a esta solicitud:

- ☐ Clinic Notes (Notas clínicas) Visit Dates (If Applicable):_____
- ☐ Progress Notes (Notas de progreso)
- ☐ History and Physical (Historia y Física)
- ☐ Discharge Summary (Resumen de alta)
- ☐ Lab Reports (Informes de laboratorio)
- ☐ Imaging Reports (imagina informes)
- ☐ Medications List (Lista de medicamentos)
- ☐ Behavioral Health (Salud mental)
- ☐ Nutrition (Nutrición)
- ☐ Other (Otro):_____

Signature:_____ Date:_____