La Misión Family Healthcare Medical and Dental Services

19780 HWY 281 South
San Antonio, TX 78221
(210) 626-0600

- An eligibility appointment needs to be scheduled prior to your medical/dental appointment.

#1	One form of Identification needed **for each adult family member**	Photo ID (patient only)	Driver's License
		Resident alien card	Passport
		State ID card	Credit/debit card with photo

#2	Copy of Social security card **for every member of the family** (if applicable)

#3	Proof of Address **(need ONLY one)**	CPS bill	Cable bill
		Water bill	Telephone bill
		Lease agreement	Medicare/Medicaid/CHIP letter
		Automotive insurance	Food stamp letter

#4	**Type of Income** For each member of the family working	**Required Income proof**
	Self Employed	Need Copy of the Current or most recent **Income Tax Return (all of the pages)**
	Receives pay stubs for work	Bring one **month's worth of paystubs (for the last 30 days)** for each member of the family working
	Cash only income	Pick up & get the **Income Verification Form** signed by your employer prior to coming into the eligibility appointment (Form is good for 6 months)
	Other Type of Funding For each member of the family	
	Social Security	Recent **Social Security Letter**
	Child Support & SSI	**A copy of the Official Child Support or SSI Letter**
	College Student	Recent Educational **Student's Loan Letter**
	Unemployed	**Texas Workforce Letter**
	Not working	Pick up a **Financial Support by Third Party Form** & get it signed by someone who is helping you while you are unemployed

Disclaimer/mandatory: all paperwork is required in order to qualify for any discounts. You will be rescheduled for an eligibility appointment if you do not have any of the paperwork displayed below. **Discounts do not apply for any outside services such as medical labs.**

DENTAL ELIGIBILITY

PLEASE BE ADVISED DENTAL ELIGIBILITY IS DONE ON A WALK-IN BASIS ON FRIDAYS ONLY BETWEEN 8:30-2:30

FIRST FRIDAY OF THE MONTH WE DO ELIGIBILITY FROM 10:00-2:30

PLEASE ENSURE THAT YOU BRING ALL DOCUMENTS NEEDED, OTHERWISE WE WILL NOT BE ABLE TO COMPLETE YOUR DISCOUNT

DOCUMENTS NEEDED FOR ELIGIBILITY

- PROOF OF INCOME
- PROOF OF ADDRESS
- PHOTO ID
- SOCIAL SECURITY CARD (YOURSELF AND FAMILY)

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Client's Statement of Self-Employment Income
Declaración de Ingresos Del negocio propio Del cliente

*This determination of eligibility is valid for **90 days/3 months***

1. Name of the person having Self-Employment Income
   Nombre de la persona que tiene Ingresos de negocio propio
   _____
2. Give the number of months covered by this Income statement
   Del número de meses que cubre esta declaración de ingresos _____
3. Describe what you did to earn this money:
   Describa lo que hizo para ganarse este dinero: _____
   _____
4. List your business Income and Expenses (Important: Attach receipts, invoices, or other verifying papers).
   Anote los ingresos de su negocio (Importante: Agregue recibos, facturas, e otros comprobantes).

Date	**Kind of work**	**Amount**
Fecha	Que clase de trabajo	Cantidad
		$
		$
		$
		$
		$
		$
		$
		$
		$
Total Self-Employment Expenses		$

For Internal Use

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I certify under penalty of perjury that the information I have provided is true and complete to the best of my knowledge, including information about income of each household member. I understand that giving false information could result in being disqualified for future programs.

Certifico bajo pena de perjurio que la información que he proporcionado es verdad y es completa al mejor de mi conocimiento, incluyendo información sobre los ingresos de cada miembro del hogar. Entiendo que dar información falsa podría causar ser descalificado para futuros programas.

Patient Signature/Firma: _____ ***Date/Fecha:*** _____

Signature of Representative: _____ ***Date:*** _____

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○ Cash income

INCOME VERIFICATION FORM

Name: _____ Social Security No.:_____

Above person has applied for services at ASCENSION DEPAUL SERVICES.
To determine eligibility for the family, all earnings must be verified.
This determination of eligibility is valid for **1 year**.

EMPLOYER MUST FILL OUT IN INK
Supervisor is required to fill out below

1. Is the person named above, employed by you? ○ Yes ○ No
   a) Is the employee seasonal? ○ Yes ○ No
      i. If yes, give average monthly income _____
   b) Does the person receive tips? ○ Yes ○ No

2. How often is this employee paid? Daily ○ Weekly ○ Biweekly ○ Monthly

3. Does employee have health insurance? ○ Yes ○ No

4. Company/Employer Name: _____

On chart, please give earnings for the last 30 days

Date Paid	Gross Income
1.	
2.	
3.	
4.	

Address: _____ Phone No.: _____

I certify under penalty of perjury that the information I have provided is true and complete to the best of my knowledge.

Signature: _____ Date: _____
(Supervisor)

After completion, please give this information to employee. All information provided will be kept confidential and will not be forwarded to any outside or government agencies.

Internal Use Only		
Weekly pay	***X (multiply by amount/payment)***	***52 weeks***
Calculations:		
Signature of Representative: _____ ***Date:*** _____		

Revised 05.13.2021

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☐ Immigrant status

☐ Unemployed

FINANCIAL SUPPORT BY THIRD PARTY STATEMENT

Client name:_____ Social Security No.:_____

To determine eligibility for the family, all income must be verified.

*This determination of eligibility is valid for **90 days.***

THIRD PARTY MEMBER MUST FILL OUT IN INK

1. Does the person named above receive financial support from you? ☐ Yes ☐ No

2. How often does this person receive financial support? ☐ Daily ☐ Weekly ☐ Biweekly ☐ Monthly

3. Amount of assistance? **$** _____

Internal Use Only

Name of Third Party: _____ Relationship: _____

Address: _____ Phone No.: _____

Signature: _____ Date: _____
(Person supporting/third party)

After completion, please give this information to personnel/client. All information provided will be kept confidential and will not be forwarded to any outside or government agencies.

DECLARATION OF NO INCOME:

I, _____, do hereby declare that I have no documented proof of income but I am receiving financial support from the third party named above.

I certify that the information above is true and correct to the best of my knowledge and belief. I understand that the information will be certified to the extent possible and that giving false information could result in my being disqualified for fraud.

Patient Signature: _____ Date: _____

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Registration Form

Patient Information

First Name:		**Last Name:**		
Birth Date:		**SSN:**	**Sex:** M	F
Street Address:				
City:		**State:**	**Zip:**	
Phone Number: (Home)		**(Mobile)**	**(Work)**	
Employer:		**Occupation:**		
Marital Status:	Minor	Single	Married	Separated	Divorced
Ethnicity:	Hispanic	Anglo/White	Asian/Pacific Islander	Black	Other:

Spouse or Responsible Party Information

First Name:		**Last Name:**	
Birth Date:		**SSN:**	**Sex:** M F
Street Address:			
City:		**State:**	**Zip:**
Phone Number: (Home)		**(Mobile)**	**(Work)**

Insurance Information (Please give your insurance card to the receptionist)

Insurance Provider:
Policy Number:

In Case of Emergency

Name of Emergency Contact:	**Phone Number:**

Consent to Treatment

The above information is true to the best of knowledge. I consent to be examined and to receive treatment from La Mision Family Health Center. I also authorize my insurance benefits to be paid directly to Ascension DePaul Services. I understand that I may be responsible for non-covered charges. I also authorize La Mision to release any information required to process my claim.

Patient/Guardian Signature: **Date:**

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Registration Form

Patient Health History

First Name:	**Last Name:**
Birth Date:	**SSN:**
Date of last physical with a medical doctor:	**Date of last dental exam:**

Do you have any of these conditions? Circle Y or N

Y N **Have you ever been told that you need pre-med, or medication, before a dental visit?**
Y N **Prosthetic cardiac valves**
Y N **Prosthetic material used for cardiac valve repair**
Y N **Previous Infective Endocarditis**
Y N **Unrepaired cyanotic heart disease or repaired congenital heart disease, with residual shunts or valvular regurgitation at the site of or adjunct to the site of a prosthetic path or prosthetic device**
Y N **Cardiac transplant with valve regurgitation due to a structurally abnormal valve**
Y N **Have you ever had a reaction to a local anesthetic**
Y N **Have you ever experienced complications or illness following a dental treatment**
Y N **Have you ever been treated for osteoporosis or have you previously taken bisphosphonates**
Y N **Have you ever been told you were not eligible to be a blood donor**
Y N **Are you pregnant?**
If yes, what is your due date:
Y N **Are you nursing?**
Y N **Have you ever been hospitalized**
When_____ Which hospital_____
Y N **Are you allergic (i.e.: itch, rash, swelling, etc) to any medications? If so, please list them below:**

Circle any conditions below that you think you have or have had in the past:

Heart Disease	Kidney Disease	GERD/Reflux
High Blood Pressure	Liver Disease	Anaphylaxis
Angina/Chest Pain	Lung Disease	Jaundice (other than at birth)
Shortness of Breath	Sickle Cell Disease	Artificial Joint/Limb
Stroke	Epilepsy or Seizures	Implant Prosthesis
Artificial Heart Valve	Glaucoma	Chemotherapy
Hemophilia (Bleeding	Emphysema	Dialysis
Disorder)	Tuberculosis (TB)	Cold Sores
Bruise Easily	AIDS/HIV (related complex)	Hay Fever
Blood Transfusion	HIV Positive	Swollen Ankles
Anemia	Shingles	Drug Addiction/Drug Abuse
Thyroid Disorder	Asthma	Psychiatric Treatment
(Hypo/Hyperparathyroidism)	Arthritis	Fainting/Dizzy Spells
Diabetes	Herpes	Skin Rash/Hives
Cancer	Hepatitis	

Do you have any condition not listed above? If so, please list:

I have reviewed the medical history and confirm it adequately states present and past conditions.

_____

Patient Signature **Date**

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Medication List

Date:_____ Pharmacy:_____

Patient Name:_____ Pharmacy phone number:_____

Medication	Dosage	How often do you take this medication?	Which doctor prescribed?	Doctor's phone number

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Patient Responsibilities

Please initial:

_____**Patients are responsible** for providing La Mision with accurate information regarding Patient's current financial status or any changes in the Patient's status. La Mision requires one month's income, proof of residence, and identification to determine eligibility. Eligibility is required before treatment is rendered. The information assists La Mision in determining the Patient's eligibility for services.

_____**Patients are responsible** for providing La Mision with complete and accurate health information to assist La Mision in providing proper care and services.

_____**Patients are responsible** for paying for services in full at the time the services are received. There will be no refunds once treatment is started.

_____**Patients are responsible** for paying any and all outstanding balances, including no show fees before being scheduled an appointment.

_____**Patients are responsible** for using any advance payment or credit within one year of initial payment.

_____**Patients are responsible** for paying for any copies of dental records that they request, which will be printed in-office for a $10.00 fee.

_____**Patients are responsible** for utilizing La Mision services responsibly which includes keeping scheduled appointments. While La Mision staff may do a courtesy call, the Patient is ultimately responsible for knowing when their appointments are scheduled. Missed appointments will incur a $25 No Show Fee. Patients arriving *more than 15 minutes* late may have their appointments cancelled.

_____**Patients are responsible** for notifying La Mision to cancel or reschedule an appointment within a 24-hour notice, which includes leaving voicemail messages. Patients who give less than a 24-hour advance notice of cancelling or rescheduling their appointment will incur a $25.00 fee. Patients who have three consecutive cancellations, rescheduling or no shows will be placed on a six month probationary period.

_____**Patients are responsible** for the supervision of their children while in the La Mision facility.

_____**Patients are responsible** for cooperating with La Mision to uphold safety standards and participate in activities that are designed for Patient safety and the safety of others during the Patient's visit to La Mision.

_____

Patient Signature **Date**

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NOTICE TO DENTAL PATIENTS

DENTAL FEES WILL BE INCREASING AS OF JANUARY 1, 2021. IF YOU ARE A PATIENT WITH A CURRENT TREATMENT PLAN, YOUR FEES WILL REMAIN THE SAME UNTIL YOUR 6 MONTH RECALL APPOINTMENT.

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Registration Form

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions related to disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health and Safety Code 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose the individual's protected health information. Authorization is not required to disclosures related to treatment, payment, health care operations, performing certain insurance functions or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPPA, the Texas Medical Privacy Act, or other applicable laws.** Individuals cannot be denied treatment based on failure to sign this authorization, and refusal to sign this form will not affect the payment, enrollment, or eligibility benefits.

Patient Information

First Name: _____ Last Name: _____
DOB: _____ Social Security #: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell #: _____
Email Address (optional): _____

The above patient authorizes Ascension dePaul's La Mision Family Healthcare on 19780 US HWY 281 S. SA, TX 78221 to disclose patient protected information to:

First Name: _____ Last Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Email Address (optional): _____

Reason For Disclosure (please circle all that apply):

Treatment/Prescriptions
Billing Information
Appointment Information
Other:_____

EFFECTIVE PERIOD: This authorization is valid until earlier of the occurrence of the death of the individual, the individual reaches age of majority, or permission is withdrawn; or until
MONTH_____DAY_____YEAR_____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Ascension DePaul La Mision Family Healthcare. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health prior to revocation or otherwise permitted by law without my specific authorization or permission, including disclosures covered as provided by TX Health and Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____

Patient Signature **Date**