We Care Clinic

Patient Registration

Patient Information

Name_____

LAST FIRST MIDDLE

Preferred Name (If Applicable) _____

DOB _____ Sex _____ Race _____ Marital Status _____

Preferred Language _____ Email _____

Address _____

STREET CITY STATE ZIP CODE

Ph. #1 _____ Ph. #2 _____ Ph. #3 _____

How did you hear about us?_____

Employer

Employment ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Self Employed ❑ Retired

Company Name_____

Address _____

STREET CITY STATE ZIP CODE

Phone Number _____Occupation_____

Emergency Contact

1. Emergency Contact Name _____

   Relationship to Patient_____ Phone Number_____

2. Emergency Contact Name _____

   Relationship to Patient_____ Phone Number_____

I attest that all of the above information is correct and acknowledge that it is my responsibility to let We Care Clinic know as soon as possible if any of my information changes.

_____ _____

Patient Signature Date

We Care Clinic

Office Policies

Change of demographics

If you change your phone number, address, etc, please let us know as soon as possible so we can update our system.

Chronic medical conditions require follow-up

Chronic medical conditions such as diabetes, hypertension, depression, and anxiety require frequent follow-ups to ensure the best care possible. Once patients with chronic medical conditions are stable on their medication, they need a follow-up every 3 months. Patients with *other* chronic medical conditions need a follow-up every 3-6 months, depending on their care plan. Medications may not be refilled unless patients keep their follow-up appointments.

Urgent Care Center, ER, or Hospital Stay

Please contact our office after you are discharged to update us on your condition and the place where you were evaluated so we can obtain records and schedule a follow-up visit. Per patient safety standards, you must be seen within 7 days of discharge.

Medication Refill Policy

It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days, so do not wait to call. Medication refills will only be addressed during regular office hours (Monday – Friday, 8:00 am – 5:00 pm). Please notify the office the next business day if you are out of medication after hours. No prescriptions will be refilled on Saturday or Sunday. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

Medications, Supplements, and Vitamins

Patients must bring their medications, supplements, and vitamins to all visits in original bottles. It is for your safety. It is important to make sure there are no adverse interactions with your medications. Also, it helps us make sure you are not taking double doses of the same medications, supplements, and vitamins . We have seen patients not realize they are taking the same medications, supplements, or vitamins twice.

Telephone texting Dr. Alvarado

Our platform SigmaMD will allow us to send and receive text messages. I understand that during the weekend, I may contact Dr. Alvarado via text messages during the hours of 9am - 5pm. A return message might be delayed for up to 3 hours. I understand and agree that electronic communication is not an appropriate means of communication regarding an emergency or other time-sensitive issues or for inquiries regarding sensitive information. In the event of an emergency, or a situation in which the patient could reasonably expect to develop into an emergency, the patient shall call 911 and follow the directions of emergency personnel.

We Care Clinic

Text Contact Consent

I authorize We Care Clinic to contact me via text message to better serve my needs. Our platform, SigmaMD, can be used to send HIPPA-compliant messages.

Late arrivals, cancellations, and no-shows

Please arrive 10 minutes before your appointment to allow for check-in and any paperwork. We ask for 48-hour notice to cancel or reschedule. Patients arriving 15 minutes or more past their scheduled appointment time may be rescheduled. Failure to give proper notice for cancellations or rescheduling may result in a $25 missed appointment fee. Patients with three (3) no-shows in 1 year may be considered for dismissal from the practice.

Making appointments

You can make your appointment through our platform, SigmaMD. If there are no appointments available, please call the office so we can schedule your appointment as soon as possible.

Acknowledgement of receipt of notice of privacy practice

I acknowledge receiving and reading a copy of We Care Clinic's "Notice of Privacy Practices." The notice describes how We Care Clinic may use and disclose my protected health information (PHI), the restrictions on the use and disclosure of my healthcare information, and my rights regarding my PHI.

I acknowledge that I have read, understood, and agreed to the policies outlined in this document.

Printed name:_____

Signature:_____ Date:_____

We Care Clinic

Financial Policy

# Of Memberships	Category	Annual Cost	Annual Cost if Paid in Full	Monthly Cost
	Adult Patient	$960	$840	$80/monthly $70/monthly with annual payment paid in full upfront.
	Child (5years old - 17 years old	$600	$480	$50/monthly $480/monthly with annual payment paid in full upfront.

By signing below, I hereby authorize We Care Clinic to initiate charges to my credit or debit card for my **annual/ monthly fee (circle one) in the amount of _____.** I authorize periodic payments of my Direct Primary Care (DPC) fee and any additional fees that I incur since my last billing date. I understand that my participation in DPC is continuous, and charges will continue until my membership contract concludes, or I formally terminate my membership.

I hereby elect the following payment terms (please initial choice):

1. _____ I elect to pay my DPC Membership fee **IN FULL** in the amount of **$840.**
2. _____ I elect to pay my DPC Membership fee in **MONTHLY** installments of the amount of **$80.**
3. _____ I elect to pay using the family discount, the following family members will be joining me (list their name and relation to you)

_____

Please circle: MasterCard VISA Discover American Express Care Credit

Name on Card: _____

Credit Card# _____ Expiration Date ____/____ CVV: _____

_____I will be using my HSA account. HSA information_____

_____ _____

Patient (Contract) Signature **Date (mm/dd/year)**

_____

Patient (Contract) Printed Name

_____ _____

Credit Card Holder Signature **Date (mm/dd/year)**

_____

Credit Card Holder Printed Name

Returned checks

The charge for a returned check is $35. You must pay in full for the check amount and the returned check fee within 10 days.

Forms

If you need forms to be filled out by the provider, some forms may require a fee upon returning the signed forms to you.

We Care Clinic

Descriptions of Service

Your monthly Direct Primary Care (DPC) Membership Fee entitles you to unlimited covered office visits. Comprehensive Primary Care Services provided in your membership include the following:

- Allergies
- Annual preventative health visits
- Autoimmune conditions
- Birth Control
- Cholesterol management
- Chronic kidney disease
- Chronic Knee Pain
- Cold/flu/pneumonia
- Common sports injuries
- Concussion Care
- Contraception counseling
- COPD/asthma
- Depression/anxiety
- Diabetes
- Discounted joint injections
- Discounted labs
- Elbow injuries
- Hand/finger injuries
- Heart failure
- Hip Injuries
- Infections
- Men's health
- Neck injuries
- Osteoporosis Care
- Plantar Fasciitis
- Screening and treatment of STDs
- Shoulder Injuries
- Skin conditions
- Sleep disorders
- Thyroid problems
- Travel medicine

The DPC model is directly paid by the patient for both access and primary medical care. We Care Clinic does not accept or bill third party payers.

You can pay the DPC monthly fee with your Health Savings Account (HSA). You cannot pay using a Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA).

Due to regulatory restriction, the DPC model is not available to patients who are eligible for or enrolled in Medicare, Medicaid, or other government healthcare programs nor HMO insurance plans.

We Care Clinic

Fee Agreement
(Please initial below)

1. _____ I acknowledge and understand that monthly fees are due on the 1st of every month.
2. _____ I acknowledge that my membership may be terminated for non-payment.
3. _____ I acknowledge and understand that I am required to provide a credit card (to be kept on file) to participate in the DPC Membership or pay the annual membership in full.
4. _____ I acknowledge and understand that my DPC Membership Fee will not be pro-rated.
5. _____ I acknowledge and understand that the DPC Membership Fee is automatically charged, and it is my responsibility to notify We Care Clinic of any changes with my card information. You can also update your information on the app.
6. _____ I acknowledge and understand that fees incurred outside of my DPC Membership Fee are due at the time of service.
7. _____ I acknowledge I must sign up for the minimum of three consecutive months of DPC.
8. _____ I acknowledge and understand that We Care Clinic may add or discontinue included services without notice.
9. _____ I acknowledge and understand that We Care Clinic may change my monthly fee at any time (but no more than once per calendar year), and that I will be given at least sixty-day notice of such fee schedule changes.
10. _____ **I acknowledge and understand that I am responsible for any charges incurred for health care services outside of We Care Clinic including but not limited to emergency room, urgent care, hospital and specialty services, imaging, labs, and pharmaceuticals.**
11. _____ I acknowledge and understand that We Care Clinic will NOT be required to reimburse me for any changes that I may incur for any care outside of the We Care Clinic.

We Care Clinic

Insurance Disclosure

(Please initial below)

- _____ I acknowledge and understand that this agreement **DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE NOR IS IT A CONTRACT OF INSURANCE** and that it provides only the health care services specifically described with the agreement.
- _____ **I acknowledge and understand that this agreement does not substitute for health insurance.** I understand that We Care Clinic will not bill insurance carriers, Medicaid, Medicare, or Medicare advantage health plans for any service provided by We Care Clinic.
- _____ I acknowledge and understand that We Care Clinic does not guarantee reimbursement of any We Care Clinic service or fees from any third-party health plans, including insurance plans and savings accounts (health savings of flexible spending).
- _____I confirm that I the patient/member am **NOT** a Medicare beneficiary, and I am **NOT** currently enrolled in Medicare, Medicaid, or any other government plan or HMO insurance.

Cancellation Policy
(Please initial below)

- _____ I acknowledge and understand that We Care Clinic may cancel this Agreement at any time and for any reason, without condition.
- _____ I understand that We Care Clinic will **NOT** terminate this Agreement solely based on my health status.
- _____ I acknowledge and understand that I must provide a written 30-day notice cancellation and that fees will continue to be auto-charged until We Care Clinic receives such notification. You can find a copy of the written notice in the office.
- _____ I acknowledge and understand that We Care Clinic may terminate this Patient Agreement for non-payment of fees.
- _____ I acknowledge that if I cancel the DPC membership and do not reach the minimum requirement of 3 months and want to join again, I will have to pay a $50 fee and pay a total of 3 months on the first day of my new term.

We Care Clinic

Consent & Direction for Release of Protected Health Information (PHI)

In compliance with HIPAA (Health Insurance Portability and Accountability Act) to help protect your financial and health information, we ask that you complete this form. You may change your answers to this form at any time. We will keep a digital copy on file in your chart. We will endeavor to follow your wishes except when required by law, as is described in the Notice of Privacy Protection statement, which you have read and signed. Regarding the release of your health information, please read through the listed below and check the box that reflects your wishes.

Please circle your response to the following:

1. **Voice Messages** - May we leave messages on a voicemail at home or on your cell phone to discuss appointments or treatments? **Yes** **No**
2. **Spouse Discussions** - May we discuss your appointments/treatment with your spouse? **Yes** **No**
3. **During Examination -** We Care Clinic may speak with all persons accompanying me during my examination directly and/or allow them to hear all information or discussion indirectly. I understand that if I don't want that person privy to the conversation, I must ask that person to leave the exam room. **Yes** **No**
4. **Telephone Contacts -** I consent to receive all information regarding appointments, laboratory, radiology, and other testing results, as well as financial information, including reminders for outstanding bills on my home telephone and/or personal cellular phone. **Yes** **No**
5. **Electronic Messages** - I consent to receiving educational emails or text messages. **Yes** **No**

HIPAA, Privacy Communications

I understand that under the HIPAA (Health Insurance Portability and Accountability Act of 1996) and its subsequent regulations and Texas privacy laws.

Please initial.

- _____ I have certain rights to privacy regarding my protected health information (PHI).
- _____ I have reviewed We Care Clinic Notice of Privacy Practices and understand my rights contained in the notice and acknowledge that it is available by request.
- _____ I understand that any and all methods of correspondence may be added by We Care Clinic to the patient's documented medical record.
- I understand that We Care Clinic requires and encourages the use of the patient portal or encrypted email as a secure method of communication. We Care Clinic does not and will not communicate via unencrypted email, fax, text messages, picture messages, social media, or online video conferencing, as these are not secure methods of communication. We Care Clinic makes every effort to comply with applicable federal and state privacy laws and regulations.

Printed Name: _____

Patient Signature: _____Date: _____

Email Address: _____

Phone #: _____