RFP – El Rio Patient App Q & A

MARCH 4, 2019
9:00AM – 10:00AM
MANNING I – CAPTAINS ROOM

Is there a specific date of build for the initial app once the contract is awarded (June 1)?

Break development into versions/phases, and break those versions/phases into sub-phases so we can see/test by the 90th day.

Who would be the product owner(s) on the El Rio side? And will those product owners have the right amount of dedicated time in their schedule to support the necessary approvals.

We have a dedicated Project Manager and that person will be responsible in making sure they have the time and resources to commit to be able to meet our deadlines. Each part of this application might have different product owners and our Project Manager will work with them.

Does El Rio desire to have its own rights to the app?

Yes, we want to own it. We understand from the development environment that there might be some code references that vendors reuse and are have ownership of those pieces.

With the strong connection to NextGen, what about data on providers and location? Would that come from NextGen? Or another data source?

The data lives on our El Rio website.

Do you currently have a service to handle translation of English content to Spanish?

No, the vendor will need to do that.

Have you conducted any consumer research or discovery to prioritize the feature list in Section A of the RFP document? If not, are you looking for a partner to help you validate this scope via research?

We would entertain a bid for the partner to be able to conduct research.

Do you already have a measurement plan in place to be able to report on the success of this new app? Or, will you be looking for your chosen partner to lead on this?

Yes, if possible, we expect to draw from app analytics.

Does El Rio Health have an existing marketing strategy for this new app? If so, can you share the makeup of that plan?

No, we do not. The vendor would work with our Marketing Coordinator for that plan.

Is the expectation that Vendor have a pre-built solution for all requirements in this RFP?

We are 100 percent open with custom development, it would allow more flexibility in what we're trying to accomplish.

What is the timeframe for Vendor solution demonstrations?

We would like an all included proposal and line-itemed. Proposal deadline will be extended based upon the Q & A getting posted to the website. We want a wire frame to look at as part of the proposal (i.e. mock).

Are there preferred pricing structures for App Development, Implementation and Ongoing support?

The pricing could be general; however, at some point we will start wire framing and mocking up designs, we would expect the price to wind down to a more fixed amount.

What is the expected date of contract award?

We expect to issue award of contract on June 1.

Can the proposal be submitted via email by the closing and time; and then followed by a sealed hard copy of proposal sent via mail the next day?

No

If sealed hard copy proposal is the only means of submittal allowed, can we request the RFP proposal deadline date and timeline to be extended by 1 day to March 12, 2019 4:00 PM MST.

The deadline has been extended to March 27, 4:00 p.m. MST.

Can the desired App functionality listed be developed, tested and deployed in a phased manner?

Yes

If so, please provide guidance on envisioned phases, prioritized functionality expected to be deployed in each phase, and the target dates for each of these phase.

90-day Initial Wire Frame Phases
Phase 1 – 5 months
Phase 2 – 4 months = Total 1-year project
Phase 3 – 3 months

Are you intending to have native IOS and Android Apps downloadable from Apple and Play Stores? or would a responsive web application (html5) would also work fine?

The idea would be that they are posted to both stores and optimized for the current supported devices. We are okay with html5 used inside the app as long as it displays properly in both apps and delivers the functionality/experience.

Are there Development and Test NextGen instances available at El Rio with all required APIs configured to aid development and support of the envisioned Patient App?

Yes, we do - multiple non-production. Later this year we will be upgrading to Spring Release 5.9.3. The enterprise APIs as well as the smart FHIR APIs; we plan to have those available later in the year. NextGen will work with the selected vendor that is awarded the contract.

Should the app have additional biometric security, such as fingerprints / facial recognition etc.

Yes, whatever the native callouts are like apple touch id, face id and Android has their equivalence. We want to use what Google and Apple currently have in their SDKs.

Are there any minimum mobile hardware that the app should support such as iPhone 5 and above, Samsung S5 and above (for example?

Currently supported iPhone non-end of life, non-end of supported iPhones, as well as for Android (Samsung Galaxy products and Google pixel products).

Are there any minimum mobile OS versions that the app should support such as Android Lollipop 5.0 & above, iOS 5 & above?

For IOS, 12 and above (what Apple is currently supporting). And for Android, 5 and higher. Should a vendor already support higher than what's listed (e.g. 6.0) and development for 5.0 will be a significant overhead cost; please notate on your submission so we can deduct X amount for testing or other types of items. Apple makes things simple; Android is a more complex area. We want to hit the majority of devices that are used within the United States.

Is it safe to assume that NextGen can provide APIs for all the desired features enlisted?

Yes, however, we would need to develop and test for them to be fully functional through 2019.

If required NextGen APIs DO NOT exist to fulfill a specific feature, will NextGen allow El Rio (and consequently Vendor) to develop required APIs for read & write operations OR will Vendor have to wait for NextGen to make such an API available?

Yes, NextGen would allow for customized API until they have it available.
Multiple ways to search for appointments - Can you expand, such as by provider, by location etc.

Online scheduling by site then by provider name and appointment date/time.

Do each type of appointment have preferred time duration i.e. 15 min, 30 min etc.

Varied by appointment types; most adult appointments are 20-minute appointment types and most pediatric are 10-minute types; however, there are some appointment type exceptions that may run longer. We are in the process of streamlining that and will make it more identifiable.

Should the appointment reflect on any personal calendar i.e., Gmail calendar / outlook / etc. or can the appointments be shown within the app

We would like an option to add it to a personal calendar; does not have to be overly complex (e.g. email to patient with option to add it to calendar) as well as push notifications for reminders.

Are reminders or alerts required before the appointment such as a day before or an hour before either via text to their mobiles or should the mobile app alert the user on predefined context of the appointment

The day of would be great; a series of appointment reminders going through NextGen as well as API configuration. An ideal feature would be for the patient to get the reminder and have the opportunity to cancel and be removed immediately from the Practice Management portion in NextGen. We can provide the content. We have to maintain certain level of HIPPA security and cannot necessarily generate alerts to the notification identifying location of appointment. Specific information needs to remain inside the app.

Assuming "highlighting appointment location" feature will be implemented using static images.

Google Maps

Should directions to the selected location address be integrated with google maps on the mobile with handshake to google maps & open maps, or should the app embed google maps?

We would provide an image of the center and it say, "Please check-in here" with a picture of the clinic so patients know where to go to check in.

Mapping of the building / highlighting location of the appointment within the building; Can we assume that this would be a static image?

Static image

NextGen Patient Portal/App is a web application. Does El Rio envision single sign-on between NextGen App and the new App? Is there a mobile app for NextGen?

We would prefer a single login; however, this may need to be phased in.

Is there a mobile app for NextGen?

Yes, there is. The hope is that it will be seamless getting from the portal to your app. There will be a separate login for ours and for NextGen. NextGen controls the authentication database for their patient portal app; we do not have a direct tie-in. We want to be able to click from one app to another. There should probably be some further discussion of what the login is going to look like and what the capabilities are once the APIs are fully developed.

What is the scope of WebChat/Text integration for appointments? Is this another app to be launched/integrated?

The chat/text are provided by Genesis pure connect; currently have chat/text platform built. Chat is currently available on our website; it is redirected to chat@elrio.org. Text messages provides the ability to text to/from our main number. What should be available is the chat@elrio.org and should be in an HTML5 driven website. If phase one is directing to our chat website, we just want to be sure all of the information is in there (does not have to be embedded in the app).

Is integration with telehealth app in scope?

Yes – details to be worked out in the last phase of development. NextGen partnered with OTTO Health for their telehealth solution.

Is the intent to launch the Telehealth App in a new browser OR for the Patient App to launch the Telehealth Mobile App (if one exists)?

To be determined

Can some examples of these forms be provided?

This is primarily for new patients wanting to establish care with El Rio. The hope is for them to fill out the forms prior to their visit and that data would be populated into NextGen so when the patient arrives at their appointment, they would not need to fill ou their forms on site or on paper. Same goes for check-in; if possible, if the patient could click a button to send a notification that they are on the property and the process could be started. **El Rio will provide example forms** (*See attached*). Currently we are utilizing Otech for Kiosk check-in and for forms being filled out. So, we'd like our app to allow the patient to do that work ahead of time. This is another possibility where there might be two phases; we want the ability to populate whether we're using Otech for forms (need a link to Otech) or if we're using the El Rio app.

Are both languages Mandatory? If not what are the important features that need both languages?

Yes, anything on the app we want in English and Spanish

Is the bi-lingual feature limited to content only, such as when to go to an ER?

No, we expect everything to be in English and Spanish.

Does the EMR track if the provider is running late?

Not directly.

How is this information captured in NextGen now?

Data fields are available; workflow needs to be optimized to capture the data.

How is the live Patient Check-in queue at the health center managed?

Provider workflow in-box. Data fields are available; workflow needs to be optimized to capture the data.

What is the scope of healthkit and wearable integration?

Need to integrate with Apple healthkit and Google healthkit.

What are some of the wearables that are envisioned to be integrated? And what are the types of information that are desired to be aggregated within Patient App?

Blood Pressure and weight monitoring; others to be determined over time.

How is the Apple Healthkit integration envisioned for Android apps?

Whatever healthkit Android needs to be supported

Is this a PDF document or static publishable content that will be made available by El Rio?

El Rio provides initial content and will provide updates if applicable

Assuming pay bill feature will be executed via an existing payment portal, is it safe to assume that App will not save or process any credit card information?

Yes, at this phase of development

What is the scope of Rx refills? Does this require integration with retail pharmacies outside of El Rio? How will El Rio NextGen EHR be notified when Rx is ready?

Access El Rio Pharmacy refill link on our website: https://www.elrio.org/service/pharmacy/

Assuming scope of Analytics is limited to basic app usage metrics and events. Please confirm.

Yes, for initial scope.

What does Open Chart concept mean as it relates to Access to Medical records? Isn't this already available in Patient Portal?

Open Notes (chart) - https://www.opennotes.org/

Lab results – Is charting in scope? Are trend charts in scope?

Yes, graph charts and graph trends are in scope.

What is the Service Levels expected for Ongoing Support? Will Ongoing Support include client-directed enhancements to App or will enhancements be negotiated as additional work streams on separate Statements of Work?

Pretest with pre-releases, and enhancements would be separate statement of work. If Apple/Android creates major outage – 24 hours to fix and 24 hours to post to stores.

Is there an existing Content Management System at El Rio that is envisioned to be used to create, syndicate, and publish content from? Or, is the expectation one of displaying links to health topics?

Displaying links on health topics.

How do you envision the white label use of the app? What do you plan on using for the other practices? How do you anticipate the other practices using this app?

Within our Enterprise we have two (2) databases and provide IT managed services for four (4) other Federally Qualified Community Health Centers. Within our database, there are five (5) practices. Utilization of the app for other practices TBD.

How does El Rio envision bill pay and viewing bills? Will it be under a browser on its website? Or, will it piggyback off another system it has an API for?

Right now it's a web link, but we will be contacting the vendor to see what capabilities they have to see if we can more tightly integrate.

With regard to the other practices, are they all the same instance of NextGen, Microsoft SQL and Genesis connections? Should we assume that all of those connections will be the same with different identifiers?

Within our Enterprise we have two (2) databases and provide IT managed services for four (4) other Federally Qualified Community Health Centers. Within our database, there are five (5) practices.

Contractually, vendors would work through El Rio and all the terms and conditions would flow down to the other four practices?

Yes

Mapping of the building and highlight location of appointment —> Do you already have this content? In what format?

We have an auto cad and can export to a variety of formats

Check in before arriving —> How would that work? How far in advance would they check in?

They would have to be at the facility and the recommended check-in time is 30 min. in advance; however, most sites will check the patient in and give them a disclaimer that they may not be seen until their appointment time.

English/Spanish —> Would users select language at the beginning? Would all content, menus, and buttons need to display in both languages?

Yes and Yes

Analytics —> We can certainly support app analytics. Do you have a sense of what you would like to track? How many dashboards? Cost varies depending on those factors.

To be determined based on work with the vendor

Pill Reminders - Who would input the pill schedule? Patient or physician? Would want to be cautious of liability here if reminders aren't updated correctly by either party.

From a safety and risk perspective, I would think that the patient would be best.

Med profile - ability to order off of —> What is being ordered? What payment and fulfillment system would this need to integrate with?

The patient would be able to review their active medication list within NG, and select a medication (or more than one) to be ordered. Would probably have some limits on this (like can’t request opiates or controlled substances)

EL RIO HEALTH

ADULT PATIENT REGISTRATION

Patient Information

Last Name	First Name	Middle Name

SSN (Optional):	Date of Birth (MM/DD/YYYY):

Mailing address	Apt/Suite

City	State	ZIP Code	County

Home Phone:	Day Phone:	Cell Phone:

Email address:

How would you like appointment information or reminders? (Select all that apply)	Preferred contact method: (Select one)
☐ Email ☐ Text ☐ Voice Reminders ☐ Opt Out	☐ Cell ☐ Day phone ☐ Email ☐ Patient Portal ☐ Home address ☐ Mailing address ☐ No mail to home address ☐ No voicemail ☐ No phone contact

Home Address (if different):	Apt/Suite

City	State	ZIP Code	County

Emergency Contact

Name	Relationship to Patient	Phone

As a Health Center that gets Federal funding, we must collect the following information. All of your answers are kept confidential.

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Life Partner
- ☐ Separated
- ☐ Widowed

Military Service
Are you a Veteran?
- ☐ Yes
- ☐ No

Do you speak English?
☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

Preferred Language ________________________

Housing: Where are you currently living?
- ☐ In my house / apartment (not homeless)
- ☐ Doubling-Up (with a friend/relative)
- ☐ Shelter
- ☐ Street (also car/camp/tent)
- ☐ Transitional

Family / Household
Number of Family Members ________
Monthly Income $_________________ OR Annual Income $_________________

Head of Household Name ____________________________________
Head of Household Date of Birth ______________________________

Ethnicity / Ethnic Origin (check only one)
- ☐ Hispanic – Mexican, Mexican/American, Chicano/Chicana
- ☐ Hispanic – Puerto Rican
- ☐ Hispanic – Cuban
- ☐ Hispanic – Another Hispanic, Latino/a or Spanish Origin
- ☐ Hispanic
- ☐ Not Hispanic

Race (check all that apply)
- ☐ American Indian/Alaska Native
- ☐ Asian: Chinese
- ☐ Asian: Filipino
- ☐ Asian: Japanese
- ☐ Asian: Korean
- ☐ Asian: Vietnamese
- ☐ Asian: Other Asian
- ☐ Asian
- ☐ Black/African American
- ☐ NH/PI: Native Hawaiian
- ☐ NH/PI: Guamanian or Chamorro
- ☐ NH/PI: Samoan
- ☐ NH/PI: Other Pacific Islander
- ☐ Native Hawaiian/Pacific Islander (NH/PI)
- ☐ White
- ☐ Choose not to disclose
- ☐ None of the above

EL RIO HEALTH

ADULT PATIENT REGISTRATION

Patient Information - Continued

What is your current gender identity?
- ☐ Male
- ☐ Female
- ☐ Transgender male/ Trans man/ Female-to-male (FTM)
- ☐ Transgender female/Trans woman/ Male-to-female (MTF)
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Other
- ☐ Choose not to disclose

Do you think of yourself as:
- ☐ Straight
- ☐ Lesbian or gay
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to Disclose

How would you like to be called?
- ☐ He
- ☐ She
- ☐ They
- ☐ Ze
- ☐ Sie or Zie
- ☐ Other _______________
- ☐ Choose not to disclose

What sex were you assigned at birth?
- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Choose not to disclose

Preferred Name:

____

Primary Insurance

Name of Insurance Company			Policy #
Name of Insured			Group #
Address of Insurance Co			Copay Amount $
City	State	ZIP Code	Deductible Amount $
Relationship to Patient	Effective Date		Expiration Date

Secondary Insurance (If applicable)

Name of Insurance Company			Policy #
Name of Insured			Group #
Address of Insurance Co			Copay Amount $
City	State	ZIP Code	Deductible Amount $
Relationship to Patient	Effective Date		Expiration Date

Authorizations: Notice of Privacy Practices/Consent to Treat/Release of Information

EL RIO HEALTH

ADULT PATIENT REGISTRATION

- I authorize El Rio Health to disclose limited protected health information to other persons who may answer electronic communication such as phone, text messages, or e-mail.

  Initial ____

- I acknowledge that I have read and understand the Notice of Privacy Practices for the El Rio Health dated 01/01/18. This notice provides information about my rights with regards to my health care information and how the El Rio Health will use and disclose my health care information. My initials and signature on this form acknowledges that I have been offered and/or received a copy of El Rio's Notice of Privacy Practices.

  Initial ____

- My initials on this form acknowledge that I understand my patient Rights and Responsibilities posted at any El Rio Health and that I have access to a copy of these Rights and Responsibilities upon request.

  Initial ____

- My initials on this form acknowledge that I received the Notice of Health Information Practices with which El Rio Health participates. This notice provides information about how the Health Information Exchange (HIE) works and my rights regarding HIE under state and federal laws. I have access to a copy to this notice and my rights upon request.

  Initial ____

- I consent to the rendering of care and medical/dental treatment, including diagnostic procedures and routine emergency medical/dental care by authorized clinic personnel as may, in their professional judgement, be necessary for the health of myself and/or my family. This consent will remain in effect until such time as it is revoked in writing.

  Initial ____

- I authorize the release of any of my protected health information to my insurance carrier or other payer, as needed for the purpose of obtaining payment for services provided by El Rio Health.

  Initial ____

- To assist in preventing and detecting identity theft of personal information, I agree to have my picture or my child's picture taken, or to provide a password, for the medical account.

  Initial ____

Signature of Authorization

Signature of Authorization

Patient Signature	Date
Parent/Legal Guardian	Date

Financial Responsibility

I acknowledge my responsibility to pay for care/treatment according to the fees established. Furthermore, I authorized assignment of benefits for medical/dental services to El Rio Health.

Signature	Date
Parent/Legal Guardian	Date

EL RIO HEALTH

DENTAL PEDIATRIC PATIENT REGISTRATION

Patient Information

Last Name	First Name	Middle Name

SSN (optional)	Date of Birth (MM/DD/YYYY):

Mailing Address	Apt/Suite

City	State	ZIP Code	County

Home Phone:	Day Phone:	Cell Phone:

Email address:

How would you like appointment information or reminders? (Select all that apply) ☐ Email ☐ Text ☐ Voice Reminders ☐ Opt Out	Preferred contact method: (Select one) ☐ Cell ☐ Day phone ☐ Email ☐ Patient Portal ☐ Home address ☐ Mailing address ☐ No mail to home address ☐ No voicemail ☐ No phone contact

Home Address (if different):	Apt/Suite

City	State	ZIP Code	County

Emergency Contact

Name	Relationship to Patient	Phone

As a Health Center that gets Federal funding, we must collect the following information. All of your answers are kept confidential.

Patient's Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Life Partner
- ☐ Widowed

Military Service

Is the patient a veteran?
- ☐ Yes
- ☐ No

Do you speak English?

☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

Preferred Language ________________________

Housing: Where are you currently living?
- ☐ In my house / apartment (not homeless)
- ☐ Doubling-Up (with a friend/relative)
- ☐ Shelter
- ☐ Street (also car/camp/tent)
- ☐ Transitional

Family / Household

Number of Family Members _______

Monthly Income $________________ OR Annual Income $________________

Head of Household Name ______________________________

Head of Household Date of Birth ____________________________

Patient's Ethnicity / Ethnic Origin (check only one)
- ☐ Hispanic – Mexican, Mexican/American, Chicano/Chicana
- ☐ Hispanic – Puerto Rican
- ☐ Hispanic – Cuban
- ☐ Hispanic – Another Hispanic, Latino/a or Spanish Origin
- ☐ Hispanic
- ☐ Not Hispanic

Patient's Race (check all that apply)
- ☐ American Indian/Alaska Native
- ☐ Asian: Chinese
- ☐ Asian: Filipino
- ☐ Asian: Japanese
- ☐ Asian: Korean
- ☐ Asian: Vietnamese
- ☐ Asian: Other Asian
- ☐ Asian
- ☐ Black/African American
- ☐ NH/PI: Native Hawaiian
- ☐ NH/PI: Guamanian or Chamorro
- ☐ NH/PI: Samoan
- ☐ NH/PI: Other Pacific Islander
- ☐ Native Hawaiian/Pacific Islander (NH/PI)
- ☐ White
- ☐ Choose not to disclose
- ☐ None of the above

Primary Insurance

Name of Insurance Company	Policy #
Name of Insured	Group #
Address of Insurance Co	Copay Amount $

City	State	ZIP Code	Deductible Amount $
Relationship to Patient	Effective Date		Expiration Date

DENTAL PEDIATRIC PATIENT REGISTRATION

Secondary Insurance (If applicable)			
Name of Insurance Company			Policy #
Name of Insured			Group #
Address of Insurance Co			Copay Amount $
City	State	ZIP Code	Deductible Amount $
Relationship to Patient	Effective Date		Expiration Date

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- To assist in preventing and detecting identity theft of personal information, I agree to have my picture or my child's picture taken, or to provide a password, for the medical account.

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Signature of Authorization	
Patient Signature	Date
Parent/Legal Guardian	Date

Financial Responsibility

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Signature	Date
Parent/Legal Guardian	Date

EL RIO HEALTH

MEDICAL PEDIATRIC PATIENT REGISTRATION

Patient Information

Last Name	First Name	Middle Name

SSN (optional)	Date of Birth (MM/DD/YYYY):

Mailing address	Apt/Suite

City	State	ZIP Code	County

Home Phone:	Day Phone	Cell Phone

Email address

How would you like appointment information or reminders? (Select all that apply)
☐ Email ☐ Text ☐ Voice Reminders ☐ Opt Out

Preferred contact method: (Select one)
☐ Cell ☐ Day phone ☐ Email ☐ Patient Portal ☐ Home address
☐ Mailing address ☐ No mail to home address ☐ No voicemail ☐ No phone contact

Residence Address (if different):	Apt/Suite

City	State	ZIP Code	County

If patient is under age 18, in order to collect vaccine history, please complete Birth Mother's Full Name below:

Last Name	First Name	Middle Name	If Married, Maiden Name

Emergency Contact

Name	Relationship to Patient	Phone

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Patient's Marital Status
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- ☐ Divorced
- ☐ Separated
- ☐ Life Partner
- ☐ Widowed

Military Service

Is the patient a veteran?
- ☐ Yes
- ☐ No

Do you speak English?
☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

Preferred Language ________________________

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- ☐ Doubling-Up (with a friend/relative)
- ☐ Shelter
- ☐ Street (also car/camp/tent)
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Monthly Income $_________________ OR Annual Income $_________________
Head of Household Name ____________________________________
Head of Household Date of Birth ______________________________

Patient's Ethnicity / Ethnic Origin (check only one)
- ☐ Hispanic – Mexican, Mexican/American, Chicano/Chicana
- ☐ Hispanic – Puerto Rican
- ☐ Hispanic – Cuban
- ☐ Hispanic – Another Hispanic, Latino/a or Spanish Origin
- ☐ Hispanic
- ☐ Not Hispanic

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- ☐ Asian: Filipino
- ☐ Asian: Japanese
- ☐ Asian: Korean
- ☐ Asian: Vietnamese
- ☐ Asian: Other Asian
- ☐ Asian
- ☐ Black/African American
- ☐ NH/PI: Native Hawaiian
- ☐ NH/PI: Guamanian or Chamorro
- ☐ NH/PI: Samoan
- ☐ NH/PI: Other Pacific Islander
- ☐ Native Hawaiian/Pacific Islander (NH/PI)
- ☐ White
- ☐ Choose not to disclose
- ☐ None of the above

Primary Insurance

Name of Insurance Company	Policy #
Name of Insured	Group #
Address of Insurance Co	Copay Amount $

City	State	ZIP Code	Deductible Amount $

Relationship to Patient	Effective Date	Expiration Date

Secondary Insurance (If applicable)

MEDICAL PEDIATRIC PATIENT REGISTRATION

Name of Insurance Company			Policy #
Name of Insured			Group #
Address of Insurance Co			Copay Amount $
City	State	ZIP Code	Deductible Amount $
Relationship to Patient	Effective Date		Expiration Date

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- My initials on this form acknowledge that I received the Notice of Health Information Practices with which El Rio Health participates. This notice provides information about how the Health Information Exchange (HIE) works and my rights regarding HIE under state and federal laws. I have access to a copy to this notice and my rights upon request.

  Initial ____

- I consent to the rendering of care and medical/dental treatment, including diagnostic procedures and routine emergency medical/dental care by authorized clinic personnel as may, in their professional judgement, be necessary for the health of myself and/or my family. This consent will remain in effect until such time as it is revoked in writing.

  Initial ____

- I authorize the release of any of my protected health information to my insurance carrier or other payer, as needed for the purpose of obtaining payment for services provided by El Rio Health.

  Initial ____

- To assist in preventing and detecting identity theft of personal information, I agree to have my picture or my child's picture taken, or to provide a password, for the medical account.

  Initial ____

Signature of Authorization

Patient Signature	Date
Parent/Legal Guardian	Date

Financial Responsibility

I acknowledge my responsibility to pay for care/treatment according to the fees established. Furthermore, I authorized assignment of benefits for medical/dental services to El Rio Health.

Signature	Date
Parent/Legal Guardian	Date

EL RIO HEALTH

REGISTRO MÉDICO DEL PACIENTE PEDIATRICO

Información del paciente

Apellido	Primer nombre	Segundo nombre
NSS (Opcional):	Fecha de nacimiento (MM/DD/YYYY):	
Dirección postal		Apart/Suite
Ciudad	Estado	Código postal	Condado
Teléfono de casa:	Teléfono diurno	Celular
Correo electrónico		

¿Cómo le gustaría recibir sú información o recordatorios de sus citas? (Seleccione todas las que correspondan)
☐ Correo Electrónico ☐ Texto ☐ Mensaje de Voz ☐ Optar por No

Método de contacto preferido: (Selecciona solo uno)
☐ Cel ☐ Tél/casa ☐ Email ☐Portal paciente ☐ Correo postal
☐ No correo postal ☐ No mensaje de voz ☐ No contacto telefónico

Dirección de casa (si es diferente):		Apart/Suite	
Ciudad	Estado	Código postal	Condado

Apellido	Nombre	Segundo Nombre	Nombre de Soltera

Contacto de emergencia

Nombre	Relación con el paciente	Teléfono

Como centro de salud que recibe fondos federales, debemos obtener la siguiente información. Todas sus respuestas son confidenciales.

Estado civil
☐ Soltero
☐ Casado
☐ Divorciado
☐ En pareja
☐ Separado
☐ Viudo

Servicio militar
¿Es usted Veterano?
☐ Sí
☐ No

¿Habla Usted Inglés?
☐ muy bien ☐ bien ☐ no bien ☐ nada

Idioma preferido ________________________

Vivienda: ¿Dónde reside actualmente?
☐ En mi hogar/apartamento (No desamparado)
☐ Compartiendo (con amigo/pariente)
☐ Albergue
☐ Calle (auto/campamento/tienda de campaña)
☐ Transitorio

Familia/Hogar
Número de miembros de la familia _______
Ingreso mensual $________________ o Ingreso Anual $________________

Nombre del jefe de familia ___________________________________
Fecha de nacimiento del jefe de familia _____________________________

Etnicidad/ Origen Étnico (marque solo una opción)
☐ Hispano – Mexicano, Mexicano/Americano, Chicano/Chicana
☐ Hispano – Puerto Riqueño
☐ Hispano – Cubano
☐ Hispano – Otro Hispano, Latino/a u origen Hispano
☐ Hispano
☐ No Hispano

Raza (Marque todas las que apliquen)
☐ Indio americano/native de Alaska
☐ Asiatico: Chino
☐ Asiatico: Filipino
☐ Asiatico: Japones
☐ Asiatico: Koreano
☐ Asiatico: Vietnamita
☐ Asiatico: otro
☐ Asiatico
☐ Negro/Africano Americano
☐ NH/PI: Nativo de Hawai
☐ NH/PI: Guamanian o Chamorro
☐ NH/PI: Samoano
☐ NH/PI: Otra isla del pacífico
☐ Nativo de Hawai/Pacifico Islander (NH/PI)
☐ Blanco
☐ Elijo no responder
☐ Ninguna de las anteriores

EL RIO HEALTH

REGISTRO MÉDICO DEL PACIENTE PEDIATRICO

<table>
<tr><th colspan="4">Seguro primario</th></tr>
<tr><td colspan="3">Nombre de la compañía aseguradora</td><td>Poliza #</td></tr>
<tr><td colspan="3">Nombre del asegurado</td><td>Grupo #</td></tr>
<tr><td colspan="3">Dirección de la segurador</td><td>Cantidad copago $</td></tr>
<tr><td>Ciudad</td><td>Estado</td><td>Código postal</td><td>Cantidad deducible $</td></tr>
<tr><td>Relación con el paciente</td><td colspan="2">Fecha efectiva</td><td>Fecha de expiración</td></tr>
<tr><th colspan="4">Seguro secundario (si es aplicable)</th></tr>
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</table>

EL RIO HEALTH

REGISTRO MÉDICO DEL PACIENTE PEDIATRICO

AUTORIZACIONES: NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD/CONSENTIMIENTO PARA TRATAR/ DAR A CONOCER INFORMACIÓN

- Autorizo a la Clínica de Salud El Río a compartir información protegida limitada a otras personas que pueden responder a comunicaciones electrónicas tales como mensajes telefónicos de texto o correos electrónicos.

  Iniciales ____

- Reconozco que he leído y entendido la Notificación de Prácticas pare el Centro de Salud de El Río con fecha de 01/01/18. Esta notificación provee información acerca de mis derechos en relación a la atención de mi salud y como El Río empleará y compartirá información de mi atención a la salud. Mis iniciales y mi firma en este formulario atestiguan que es me ha ofrecido y/o recibido copia de las Prácticas de Privacidad de El Río.

  Iniciales ____

- Mis iniciales en este formulario atestiguan que entiendo mis Derechos y responsabilidades como paciente y que tengo acceso a una copia de estos Derechos Y Responsabilidades cuando lo solicite.

  Iniciales ____

- Mis iniciales en este formulario atestiguan que he recibido Notificación de Información de las Prácticas de Salud en las cuales participa El Río. Esta notificación provee información acerca de cómo funciona el Intercambio de Información de la Salud (IIS) y mis derechos en relación al IIS dentro de las leyes estatales y federales. Tengo acceso a una copia de esta Notificación y mis derechos cuando lo solicitet.

  Iniciales ____

- Doy consentimiento a la entrega de atención y tratamiento médico/dental, incluyendo procedimientos diagnósticos y emergencias rutinarias por el personal clínico autorizado, cuando de acuerdo su criterio profesional, sea necesario para mi salud y/o la de mi familia. Este consentimiento permanecerá en efecto hasta tal fecha en que sea revocado por escrito.

  Iniciales ____

- Autorizo la liberación de cualquier información protegida a mi aseguradora u otro pagador, como sea indicado palos propósitos de obtener el pago por los servicios suministrados por El Centro de Salud de El Río.

  Iniciales ____

- Para asistir en la prevención y detección del robo de información personal estoy de acuerdo en que se tome mi foto y la foto de mi hijo(a) o suministrar una clave de acceso a mi cuenta médica.

  Iniciales ____

Firma de autorización	
Firma del paciente	Fecha
Padre/ guardian legal	Fecha

Responsabilidad financiera

Reconozco mi responsabilidad de pagar fo el cuidado/tratamiento de acuerdo a las tarifas establecidas. Así mismo, autorizo asignación de beneficios por servicios médicos/dentales a El Rio Health.

Firma	Fecha
Padre/ Guardian legal	Fecha

EL RIO HEALTH

REGISTRO DEL PACIENTE ADULTO

Información del paciente

Apellido	Primer nombre	Segundo nombre

NSS (Opcional):	Fecha de nacimiento (MM/DD/YYYY):

Dirección postal	Apart/Suite

Ciudad	Estado	Código postal	Condado

Teléfono de casa:	Teléfono diurno	Celular

Correo electrónico

¿Cómo le gustaría recibir sú información o recordatorios de sus citas? (Seleccione todas las que correspondan)
☐ Correo Electrónico ☐ Texto ☐ Mensaje de Voz ☐ Optar por No

Método de contacto preferido: (Selecciona solo uno)
☐ Cel ☐ Tél/casa ☐ Email ☐Portal paciente ☐ Correo postal
☐ No correo postal ☐ No mensaje de voz ☐ No contacto telefónico

Dirección de casa (si es diferente):	Apart/Suite

Ciudad	Estado	Código postal	Condado

Contacto de emergencia

Nombre	Relación con el paciente	Teléfono

Como centro de salud que recibe fondos federales, debemos obtener la siguiente información. Todas sus respuestas son confidenciales.

Estado civil
- ☐ Soltero
- ☐ Casado
- ☐ Divorciado
- ☐ En pareja
- ☐ Separado
- ☐ Viudo

Servicio militar
¿Es usted Veterano?
- ☐ Sí
- ☐ No

¿Habla Usted Inglés?
☐ muy bien ☐ bien ☐ no bien ☐ nada

Idioma preferido ________________________

Vivienda: ¿Dónde reside actualmente?
- ☐ En mi hogar/apartamento (No desamparado)
- ☐ Compartiendo (con amigo/pariente)
- ☐ Albergue
- ☐ Calle (auto/campamento/tienda de campaña)
- ☐ Transitorio

Familia/Hogar
Número de miembros de la familia _______
Ingreso mensual $________________ o Ingreso Anual $________________

Nombre del jefe de familia __________________________________
Fecha de nacimiento del jefe de familia ____________________________

Etnicidad/ Origen Étnico (marque solo una opción)
- ☐ Hispano – Mexicano, Mexicano/Americano, Chicano/Chicana
- ☐ Hispano – Puerto Riqueño
- ☐ Hispano – Cubano
- ☐ Hispano – Otro Hispano, Latino/a u origen Hispano
- ☐ Hispano
- ☐ No Hispano

Raza (Marque todas las que apliquen)
- ☐ Indio americano/native de Alaska
- ☐ Asiatico: Chino
- ☐ Asiatico: Filipino
- ☐ Asiatico: Japones
- ☐ Asiatico: Koreano
- ☐ Asiatico: Vietnamita
- ☐ Asiatico: otro
- ☐ Asiatico
- ☐ Negro/Africano Americano
- ☐ NH/PI: Nativo de Hawai
- ☐ NH/PI: Guamanian o Chamorro
- ☐ NH/PI: Samoano
- ☐ NH/PI: Otra isla del pacífico
- ☐ Nativo de Hawai/Pacifico Islander (NH/PI)
- ☐ Blanco
- ☐ Elijo no responder
- ☐ Ninguna de las anteriores

EL RIO HEALTH

REGISTRO DEL PACIENTE ADULTO

Información del paciente - Continuación

¿Cual es su identidad de género atual?
- ☐ Hombre
- ☐ Mujer
- ☐ Hombre transgénero/ Hombre Trans/ Mujer-a-hombre (MaH)
- ☐ Mujer transgénero/Mujer tranns/ Hombre-a-mujer (HaM)
- ☐ Genderqueer, no exclusivamente hombre o mujer
- ☐ Otro
- ☐ Elijo no responder

¿Se considera Usted como?:
- ☐ Heterosexual
- ☐ Lesbiana o gay
- ☐ Bisexual
- ☐ Algo más
- ☐ No sé
- ☐ Elijo no responder

¿Como le gusta que se dirijan a usted?
- ☐ Él
- ☐ Ella
- ☐ Ellos
- ☐ Ze
- ☐ Sie or Zie
- ☐ Otro ______________
- ☐ Elijo no responder

¿Qué género le asignaron al nacer?
- ☐ Hombre
- ☐ Mujer
- ☐ Desconocido
- ☐ Elijo no responder

Nombre preferido:

____

Seguro primario

Nombre de la compañía aseguradora			Poliza #
Nombre del asegurado			Grupo #
Dirección de la segurador			Cantidad copago $
Ciudad	Estado	Código postal	Cantidad deducible $
Relación con el paciente	Fecha efectiva		Fecha de expiración

Seguro secundario (si es aplicable)

Nombre de la compañía aseguradora			Poliza #
Nombre del asegurado			Grupo #
Dirección de la segurador			Cantidad de copago $
Ciudad	Estado	Código postal	Cantidad deducible $
Relación con el paciente	Fecha efectiva		Fecha de expiración

EL RIO HEALTH

REGISTRO DEL PACIENTE ADULTO

AUTORIZACIONES: NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD/CONSENTIMIENTO PARA TRATAR/ DAR A CONOCER INFORMACIÓN

- Autorizo a la Clínica de Salud El Río a compartir información protegida limitada a otras personas que pueden responder a comunicaciones electrónicas tales como mensajes telefónicos de texto o correos electrónicos.
  Iniciales ____

- Reconozco que he leído y entendido la Notificación de Prácticas pare el Centro de Salud de El Río con fecha de 01/01/18. Esta notificación provee información acerca de mis derechos en relación a la atención de mi salud y como El Río empleará y compartirá información de mi atención a la salud. Mis iniciales y mi firma en este formulario atestiguan que es me ha ofrecido y/o recibido copia de las Prácticas de Privacidad de El Río.
  Iniciales ____

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  Iniciales ____

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  Iniciales ____

- Doy consentimiento a la entrega de atención y tratamiento médico/dental, incluyendo procedimientos diagnósticos y emergencias rutinarias por el personal clínico autorizado, cuando de acuerdo su criterio profesional, sea necesario para mi salud y/o la de mi familia. Este consentimiento permanecerá en efecto hasta tal fecha en que sea revocado por escrito.
  Iniciales ____

- Autorizo la liberación de cualquier información protegida a mi aseguradora u otro pagador, como sea indicado palos propósitos de obtener el pago por los servicios suministrados por El Centro de Salud de El Río.
  Iniciales ____

- Para asistir en la prevención y detección del robo de información personal estoy de acuerdo en que se tome mi foto y la foto de mi hijo(a) o suministrar una clave de acceso a mi cuenta médica.
  Iniciales ____

Firma de autorización	
Firma del paciente	Fecha
Padre/ guardian legal	Fecha

Responsabilidad financiera

Reconozco mi responsabilidad de pagar fo el cuidado/tratamiento de acuerdo a las tarifas establecidas. Así mismo, autorizo asignación de beneficios por servicios médicos/dentales a El Rio Health.

Firma	Fecha
Padre/ Guardian legal	Fecha

EL RIO HEALTH

REGISTRO DENTAL PEDIÁTRICO DEL PACIENTE

Información del paciente

Apellido	Primer nombre	Segundo nombre

NSS (Opcional):	Fecha de nacimiento (MM/DD/YYYY):

Dirección postal	Apart/Suite

Ciudad	Estado	Código postal	Condado

Teléfono de casa:	Teléfono diurno	Celular

Correo electrónico

¿Cómo le gustaría recibir sú información o recordatorios de sus citas? (Seleccione todas las que correspondan)
☐ Correo Electrónico ☐ Texto ☐ Mensaje de Voz ☐ Optar por No

Método de contacto preferido: (Selecciona solo uno)
☐ Cel ☐ Tél/casa ☐ Email ☐Portal paciente ☐ Correo postal
☐ No correo postal ☐ No mensaje de voz ☐ No contacto telefónico

Dirección de casa (si es diferente):	Apart/Suite

Ciudad	Estado	Código postal	Condado

Contacto de emergencia

Nombre	Relación con el paciente	Teléfono

Como centro de salud que recibe fondos federales, debemos obtener la siguiente información. Todas sus respuestas son confidenciales.

Estado civil
☐ Soltero
☐ Casado
☐ Divorciado
☐ En pareja
☐ Separado
☐ Viudo

Servicio militar
¿Es usted Veterano?
☐ Sí
☐ No

¿Habla Usted Inglés?
☐ muy bien ☐ bien ☐ no bien ☐ nada

Idioma preferido ________________________

Vivienda: ¿Dónde reside actualmente?
☐ En mi hogar/apartamento (No desamparado)
☐ Compartiendo (con amigo/pariente)
☐ Albergue
☐ Calle (auto/campamento/tienda de campaña)
☐ Transitorio

Familia/Hogar
Número de miembros de la familia ________
Ingreso mensual $_________________ o Ingreso Anual $_________________

Nombre del jefe de familia ____________________________________
Fecha de nacimiento del jefe de familia _____________________________

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☐ Hispano – Puerto Riqueño
☐ Hispano – Cubano
☐ Hispano – Otro Hispano, Latino/a u origen Hispano
☐ Hispano
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Raza (Marque todas las que apliquen)
☐ Indio americano/native de Alaska
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☐ Asiatico: Vietnamita
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☐ Blanco
☐ Elijo no responder
☐ Ninguna de las anteriores

Seguro primario

Nombre de la compañía aseguradora	Poliza #
Nombre del asegurado	Grupo #
Dirección de la segurador	Cantidad copago $

Ciudad	Estado	Código postal	Cantidad deducible $

Relación con el paciente	Fecha efectiva	Fecha de expiración

Seguro secundario (si es aplicable)

Nombre de la compañía aseguradora	Poliza #

EL RIO HEALTH

REGISTRO DENTAL PEDIÁTRICO DEL PACIENTE

Nombre del asegurado			Grupo #
Dirección de la segurador			Cantidad de copago $
Ciudad	Estado	Código postal	Cantidad deducible $
Relación con el paciente	Fecha efectiva		Fecha de expiración

AUTORIZACIONES: NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD/CONSENTIMIENTO PARA TRATAR/ DAR A CONOCER INFORMACIÓN

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  Iniciales ____
- Reconozco que he leído y entendido la Notificación de Prácticas pare el Centro de Salud de El Río con fecha de 01/01/18. Esta notificación provee información acerca de mis derechos en relación a la atención de mi salud y como El Río empleará y compartirá información de mi atención a la salud. Mis iniciales y mi firma en este formulario atestiguan que es me ha ofrecido y/o recibido copia de las Prácticas de Privacidad de El Río.
  Iniciales ____
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  Iniciales ____
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  Iniciales ____
- Doy consentimiento a la entrega de atención y tratamiento médico/dental, incluyendo procedimientos diagnósticos y emergencias rutinarias por el personal clínico autorizado, cuando de acuerdo su criterio profesional, sea necesario para mi salud y/o la de mi familia. Este consentimiento permanecerá en efecto hasta tal fecha en que sea revocado por escrito.
  Iniciales ____
- Autorizo la liberación de cualquier información protegida a mi aseguradora u otro pagador, como sea indicado palos propósitos de obtener el pago por los servicios suministrados por El Centro de Salud de El Río.
  Iniciales ____
- Para asistir en la prevención y detección del robo de información personal estoy de acuerdo en que se tome mi foto y la foto de mi hijo(a) o suministrar una clave de acceso a mi cuenta médica.
  Iniciales ____

Firma de autorización

Firma del paciente	Fecha
Padre/ guardian legal	Fecha

Responsabilidad financiera

Reconozco mi responsabilidad de pagar fo el cuidado/tratamiento de acuerdo a las tarifas establecidas. Así mismo, autorizo asignación de beneficios por servicios médicos/dentales a El Rio Health.

Firma	Fecha

Revisado 07-20-2018

EL RIO HEALTH

REGISTRO DENTAL PEDIÁTRICO DEL PACIENTE

Padre/ Guardian legal	Fecha