PATIENT PAPERWORK INSTRUCTIONS

All forms in the patient paperwork packet must be completed for each patient

Responsible Party by Color: Clinical Team, Managing Team, and Preceptor

1. WHEN PATIENT ARRIVES:

- Clinical Team completes top half of **page 1** (vital signs)
    - Clinical student includes vital signs in clinical note (found in "Physical Exam" section)

2. WHEN PATIENT IS ROOMED:

- Hand clipboard to MiT. MiT secures signatures on **pages 2 - 8. (MOST IMPORTANT)**
    - Page 2: Consent to Treatment/Contact/Procedures
    - Page 4: Telephonic Consent
    - Page 5: Notification of Patient Rights/Privacy
    - Pages 6/7: Authorization of Disclosure of Protected Health Information
    - Page 8: Release of Information
- MIT flip to PHQ9/DAST/AUDIT and hand clipboard to clinical team

3. H&P

- Clinical Team will fill out the PHQ9/DAST/AUDIT scoring form during the social history
- Hand clipboard back to MiTs after H&P is finished

4. Demographic Paperwork

- MiTs work with patients to complete demographic portions of paperwork while clinical team meets with attending **(pages 9-14)**

5. Registration & Health History Form

- Clinical students will fill out the Healthcare for the Homeless-Houston Registration & Health History form after the H&P based on the patient encounter

6. Final Steps

- **Attending physician** completes bottom half of first page for billing with HHH.
- Manager performs a final audit to ensure full completion without errors

Healthcare for the Homeless-Houston Encounter Form

Date of Service:_____ New Established **First time this year**

Last Name_____ **First Name:**_____ **MI:**_____

DOB ____ / ____ / _____ **ID #**_____ **Sex:** M F

Reason for Visit:

1 _____ 2. _____

Height: ____ in. Weight: _____ Pulse: _____ BP: _____

Temp: _____ Resp: _____

PPD: _____ neg or pos Declined Given
Td: _____ Declined Given
Hep A/B: Declined Given

Medical insurance: _____

Est. Patient		New Patient		Diagnosis
99213	Office visit- low	**99201**	Prob. focused	1. ____
99214	Office visit-mod	**99202**	Exp. prob	2. ____
99215	Office visit- high	**99203**	Detailed	
		99204	Comprehensive	
		99205	Comprehensive/Complex	

Procedures:

- ☐ EKG ☐ Fingerstick: _____
- ☐ Strep results: _____
- ☐ U/A ☐ UPT
- ☐ Pap ☐ RPR ☐ Gen Probe
- ☐ Insulin R or N Units: _____
- ☐ Labs: _____
- ☐ Other: _____

Patient Disposition:

- ☐ Leave With : _____
- ☐ Appt When: _____
- ☐ Case Mgmt. Yes No Reason: _____

Signature: _____

Healthcare for the Homeless Houston
health • hope • dignity
P.O. Box 66690 • Houston, TX 77266

CONSENT TO TREATMENT

I, _____ have presented and requested to be examined by the clinicians of Healthcare for the Homeless-Houston. I consent to receive medical services.

I, _____, understand that HHH has the right to deny me services for any reason other than my ability to pay. I will be notified of any reason for termination of services.

CONSENT TO CONTACT/ DO NOT CONTACT

I, _____, ***hereby give my consent*** for Healthcare for the Homeless – Houston (HHH) to contact me at the phone number and/or address recorded in my health record, or at another address as listed below. HHH may also reveal my protected health information in an effort to find me, or leave messages for me if there is a serious health matter. HHH will not inform anyone but me of the nature of this health matter

Address/Facility: _____ Phone #: (_____) _____– _____

Patient Initials: _____ Date: _____

I, _____, ***waive my right to be contacted*** and informed about abnormal lab results, recalled pharmaceuticals, missed appointments, or other serious health matters. I am aware that not being provided with this information could result in serious health conditions. If I want to know about my lab values, reschedule missed appointments, or find out about any recalled pharmaceuticals I will follow up with HHH as I see fit

Patient Initials: _____ Date: _____

CONSENT FOR PROCEDURES

I, _____, consent to have the medical staff of HHH perform the following procedure:

Procedure:_____ Provider: _____ Witness:_____

Date/Time:_____

The risks and benefits have been explained to me. I have had the opportunity to ask questions. I fully understand the risks and benefits involved in having this procedure done.

Healthcare for the Homeless
Houston
health • hope • dignity
P.O. Box 66690 • Houston, TX 77266

NOTIFICATION OF PATIENT RIGHTS

I have received a copy of the Healthcare for the Homeless-Houston (HHH) Patient Rights and Responsibilities policy. These rights have been explained to me in a language I can understand. I was offered a chance to discuss these rights and have had any questions I asked answered.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Parent, Guardian or Personal Representative** Date

NOTIFICATION OF PRIVACY POLICY

I have received a copy of the Healthcare for the Homeless-Houston (HHH) Health Information and Privacy Policy. I, _____, know that if I have any questions about this policy or about my privacy rights, I can contact the Clinical Manager/HIPAA Compliance Officer at HHH.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Parent, Guardian or Personal Representative** Date

**If you are signing as the personal representative of the consumer, please explain your legal authority to act for this person; i.e., power of attorney, parent, healthcare provider, etc.

Healthcare for the Homeless
Houston

Healthcare for the Homeless – Houston (HHH) is committed to human rights. All patients have the following **rights** and **responsibilities**:

PATIENT RIGHTS

- You have the right to the best care that is not affected by race, color, religion, sexual orientation, national origin, creed, sex, ancestry, age, veteran status, disability or ability to pay.
- You have the right to be treated with respect and dignity.
- You have the right to know the name and qualifications of anyone who is involved in your care.
- You have the right to information that is easy to understand so that you can make good decisions about your care. This includes being told about procedures, treatments and healthcare plan.
- You have the right to take part in decisions about to your care.
- You have the right to refuse or stop treatment at any time.
- You have the right to ask for a different healthcare provider, if one is available.
- You have the right to look at and ask for copies of your medical record.
- You have the right to have all of your records and talks with medical staff kept private. However, there are limits. For example, by law, we have to report the abuse of children, elderly and disabled. If you have questions about this, please ask us.
- You have the right to ask for help entering the clinic if you have physical problems.
- You have the right to know when students or interns are to going to do your medical examinations or treatments.
- You have the right to refuse to take part in any research study or project.
- You have the right to talk to the staff if you have problems and concerns. You can ask for the agency's Grievance Policies and Procedures from any staff member.

PATIENT RESPONSIBILITIES

- You have the responsibility to work with HHH to give correct and complete information about your health.
- You have the responsibility to let us know right away if you do not understand instructions about your care or if you feel that you cannot follow the instructions.
- You have the responsibility to take part in decisions about your care.
- You have the responsibility to show respect and thoughtfulness to other clients, volunteers and HHH staff.
- You must take responsibility for your actions and what happens if you refuse treatment or decide not to take part in your care.
- You have the responsibility to be on time for your appointments or to contact us if you cannot make your appointment.

Healthcare for the Homeless- Houston **Date of Service:** _____

Patient and Client Registration Form

Please fill in as completely as possible

Last Name:_____ **First Name**:_____ **MI:**_____

Date of Birth:_____/_____/_____ **Preferred Language:** _____

Preferred First name/Nickname:_____ **Patient SSN**:_____

Gender (Circle Your Answer): Male Female Transgender male Transgender Female Other

Address: _____ **City, State, ZIP**:_____

Phone #: Home: _____ Mobile: _____ **Email**:_____

Emergency Contact Name:_____ **Relationship to Patient**:_____

Emergency Contact Phone #: _____

Sexual Orientation (Circle Your Answer): Heterosexual (or straight) Lesbian Gay Bisexual Something else Don't know Choose not to disclose

Are you a Veteran (Circle Your Answer): No Yes

Ethnicity (Circle Your Answer): Hispanic Non-Hispanic

Healthcare for the Homeless Houston
health • hope • dignity

Race: Please select all that apply

☐ American Indian	☐ Asian Indian	☐ Guamanian or Chamorro
☐ Chinese	☐ Filipino	☐ Middle Eastern
☐ Japanese	☐ Korean	☐ White/Caucasian
☐ Native Hawaiian	☐ Other Asian	☐ Other
☐ Samoan	☐ Vietnamese	☐ Unknown
☐ Other Pacific Islander	☐ Black/African American	☐ Declined to Answer

Medical Resources: Please select all that apply

☐ Medicare ☐ Medicaid	☐ Gold Card ☐ Private Insurance	☐ Healthy TX Women	☐ Other Insurance ☐ None/Uninsured

If you have your insurance card or know your Member ID #, please provide the information at the front desk reception.

Authorization for Disclosure of Protected Health Information Through Health Information Exchange(s)

Patient Name: _____

Date of Birth: _____

Harris Health Medical Record No.: _____

Harris Health System ("Harris Health") and its partner organizations use an electronic medical record system to keep information about your treatment. The electronic medical record lets your treatment team coordinate your care, improve the exchange of important information about your treatment, and reduce duplication. Your electronic medical records may have information that is needed or helpful to your care. We need you to authorize us to disclose your health information.

Harris Health's partner organizations are Federally Qualified Health Centers whose patients also obtain health care treatment at Harris Health. Harris Health's partner organizations have the ability to view the Harris Health electronic medical record of the partner organization's patients and to document in a separate area of Harris Health's electronic medical record the treatment the partner organization provides to the patient(s).

Harris Health and its partner organizations are members of three health information exchanges at this time:

(1) Greater Houston Healthconnect (www.ghhconnect.org);
(2) Memorial Hermann Information Exchange (www.memorialhermann.org/patients-caregivers/mhie); and
(3) Epic Care Everywhere (http://www.epic.com/CareEverywhere/)

Each health information exchange has health care providers that are members. You can go to the website of the health information exchange to see the up-to-date list of members of each health information exchange.

A health information exchange lets patient health information be shared electronically between providers that care for the same patient, such as physician offices, hospitals, pharmacies, labs and payers of health claims. Health information exchanges help your doctor and others who provide health care, or pay for it, share information in a secure way. Harris Health will share your protected health information, which may include your health information from a Harris Health partner organization, only through the health information exchanges if you sign this authorization. You can still authorize your doctors to share your health information to others outside of the health information exchanges by signing a separate authorization at your doctor's office or hospital when you wish to have your health information shared.

By signing this form, you agree that Harris Health may disclose your protected health information, which may include your health information from a Harris Health partner organization, to the health information exchanges and its members for the limited purpose of treatment, payment and health care operations. This authorization lets your information be shared in a new way, through a secured electronic network. It does not change who gets to review your information or the kinds of information shared. The kinds of information considered protected health information include, but are not limited to:

- Diagnosis (disease or problem)
- Clinical summaries of treatment and copies of documents in your medical record
- Results of lab tests, x-rays and other tests
- Medication (current and past)

- Personal information such as name, address, telephone number, gender, ethnicity, and age
- Treatment and services, names of providers and dates of service
- Alcohol, drug abuse, mental and behavioral health treatment
- Human immunodeficiency virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) test results and treatment
- Hepatitis B or C test results and treatment
- Genetic test results and treatment
- Genome information, if provided
- Family medical history, if provided

Authorization for Disclosure of Protected Health Information Through Health Information Exchange(s)

"I authorize Harris Health to release all of my health information in its electronic records, which may include my health information from a Harris Health partner organization, to the health information exchanges and its members for my treatment and related services. I understand and agree that this information may include information related to diagnosis and/or treatment of, or references to, **mental illness, drug abuse and/or alcohol abuse, HIV testing or status, sexually transmitted diseases, and/or other sensitive health matters**. I understand that once Harris Health releases this health information, all or part of it may become part of my medical record at a provider that is a member of the health information exchanges, and that information may be used and released as part of the receiving provider's record of my medical care. I also understand that the information sent to the health care provider through the health information exchange may be used after this for the purpose of continuity of care."

This authorization expires one (1) year from the date of signature. This authorization also may be canceled by you or your legally authorized representative at any time by sending written notice to the Harris Health Privacy Officer at 2525 Holly Hall, Suite 171, Houston, Texas 77054. Even if you cancel your authorization, it will not change releases that were made before the cancellation.

"I understand that I may choose not to authorize this release of my medical information, and that I will not be refused care because of that choice."

By signing below, I understand and agree that I am authorizing Harris Health to share my health records electronically through the listed health information exchanges as described in this authorization."

☐ Patient is a minor ☐ Patient is incompetent/incapacitated

Signature of Patient/Patient's Legally Authorized Representative Date and Time

Healthcare for the Homeless Houston

health • hope • dignity

HMIS
Release of Information
Healthcare for the Homeless-Houston

Use of a Homeless Management Information System (HMIS), is required by the US Department of Housing and Urban Development (HUD) for agencies that receive certain types of HUD funding. HMIS is not electronically connected to HUD and is only used by authorized agencies. All HMIS users have received confidentiality training and have signed strict agreements to protect clients' personal information and limit its use appropriately.

A Privacy Notice is available and it provides details of how member agencies and their employees handle client information and data sharing.

I give permission to **Healthcare for the Homeless-Houston** to collect and enter my personal information into the HMIS information system. I understand that the HMIS system is shared with and used by authorized agencies in my community for the purposes of:

- Assessing clients' needs in order to give better assistance and to improve their current or future situations.
- Improving the quality of care and service for people in need.
- Tracking the effectiveness of community efforts to meet the needs of people who have received assistance.
- Reporting data that does not identify specific people or their personal information.

I understand that:

- No restricted information about my health, medical needs, mental health or domestic violence can be shared unless I sign a separate agreement.
- Signing this release of information does not guarantee that I will receive assistance.
- I can stop participating at any time.
- All agencies that use HMIS have signed an agreement to treat my information in a professional and confidential manner.
- Unauthorized people or organizations cannot gain access to my information without my consent.

Today's Date_____

Client Name (Please Print)_____

Client Signature_____

Date: _____ Patient Name_____ MRN_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling/staying asleep or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself; or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way?	0	1	2	3
PHQ-9 TOTAL				

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult

DAST

Over the past twelve months have you:	YES	NO
Have you used drugs other than those required for medical reasons?	Y	N
Do you abuse more than one drug at a time?	Y	N
Are you **unable** to stop using drugs **when you want to**?	Y	N
Have you had "blackouts" or "flashbacks" as a result of drug use?	Y	N
Do you ever feel bad or guilty about your drug use?	Y	N
Does your spouse or parents ever complain about your involvement with drugs?	Y	N
Have you neglected your family because of your use of drugs?	Y	N
Have you engaged in illegal activities in order to obtain drugs?	Y	N
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Y	N
Have you had *medical problems* as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)	Y	N

AUDIT

Questions	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times/month	2-3 times/week	4 or more/week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you were unable to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you felt guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as the result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Healthcare for the Homeless- Houston

Homeless Verification

Client/Patient Name: _____ Date of Birth _____

Mailing address or Residence Address:

_____

_____

My Current Living Situation: Please let us know where you spent last night by checking the appropriate box below. Check only one box and provide any additional documentation you might have to our Front Desk Staff.

☐ **Street**: Sidewalk, Car, Park, Abandoned Building, Under Bridge, etc. If you spent the night incarcerated, in an institutional treatment program, (e.g. mental health, substance use disorder) or in a hospital, and you do not know where you intend to sleep AFTER your visit/release.

Please provide name of park or cross streets/intersection

_____

☐ **Permanent Supportive Housing**: This could include- New Hope Housing Facilities

Facility name_____

☐ **Transitional Housing:** This could include a temporary housing arrangement from 6 months to 2 years.

Facility name _____

☐ **Doubling Up:** Temporarily staying with friends or family

☐ **Homeless Shelter**: This could include any facility that provides meals and a place to sleep, but are limited to number of days and hours that a resident may stay at the shelter.

Facility name_____

☐ **Public Housing/Section 8**

I certify that this information presented above is true and accurate

Patient Signature_____ Date_____

Healthcare for the Homeless- Houston

Income Verification Form

Client/Patient Name: _____

Client/Patient Date of Birth: _____

Annual Income: _____

Family Size: _____

Please provide your monthly income:

Income from work	Hourly Wage _____	Monthly Income _____
Government Assistance	Monthly Income _____	Comment_____
Alimony/Child Support	Monthly Income_____	Comment_____
Other non wage	Monthly Income_____	Comment_____
Pension	Monthly Income_____	Comment_____
Social Security	Monthly Income_____	Comment_____
Interest and Dividends	Monthly Income_____	Comment_____

I attest that the information supplied on this page is true and complete

Client/Patient Signature _____ Date _____

HEALTHCARE for the HOMELESS – HOUSTON **REGISTRATION & HEALTH HISTORY**

Last name: _____ **First name:** _____ **MI**_____ **CLINIC ID #** _____

DATE OF BIRTH: _____ **SOC SECURITY NUMBER:** _____ - _____ - _____

RACE: Asian Black Hispanic White Other **MARITAL STATUS** single married separated divorced widowed

EDUCATION: GRADE SCHOOL GED HIGH SCHOOL VOCATIONAL/TECH COLLEGE GRADUATE SCHOOL

WHERE DID YOU STAY LAST NIGHT? STREET SHELTER FRIEND/RELATIVE TRANSITIONAL REHAB PROGRAM OTHER

CONTACT ADDRESS: _____ **CONTACT PHONE:** _____

HEALTH INSURANCE: MEDICARE MEDICAID VA PRIVATE INSURANCE GOLD CARD NONE

INSURANCE ID #_____ **OTHER BENEFITS?** FOOD STAMPS CHILD SUPPORT TANF SSI SSDI

WHAT KIND OF WORK DO YOU USUALLY DO? _____ **EMPLOYED?** YES / NO **INCOME: $**_____

HOW MANY CHILDREN DO YOU HAVE? _____ **HOW OLD ARE THEY?** _____

WOULD YOU BE INTERESTED IN TALKING WITH A CHAPLAIN? ____ **YES** _____ **NO** _____ **UNSURE**

HAVE YOU BEEN INCARCERATED IN HARRIS COUNTY WITHIN THE PAST YEAR? _____**YES** _____**NO**

ALLERGIES: NONE PENICILLIN SULFA LATEX IODINE OTHER: _____

DO YOU HAVE ANY HEALTH PROBLEMS? (Circle any problems you have now or you have had in the past)

ALCOHOLISM	DRUGS	BIPOLAR	DEPRESSION	HIGH BLOOD PRESSURE	CANCER	KIDNEY
HIV/AIDS	ASTHMA	HEPATITIS B/C	COPD / EMPHYSEMA	HEART PROBLEMS	SEIZURES	
DIABETES	HEADACHES	ULCERS	SCHIZOPHRENIA	ABNORMAL PAP SMEAR	ANEMIA	

OTHER PROBLEMS: _____

PLEASE LIST *ALL* THE MEDICINES YOU TAKE: _____

HAVE YOU EVER BEEN HOSPITALIZED? _____ **WHY?**_____

SURGERIES: _____

DO YOU SMOKE? NEVER YES NO **QUIT DATE:** _____ **HOW MANY PACKS A DAY?** _____ **HOW LONG?** _____

DO YOU DRINK ALCOHOL? NEVER YES NO **On a *typical* day when you are drinking, how many drinks do you have?** _____

HAVE YOU EVER *TRIED* TO QUIT?_____ **WOULD YOU *LIKE* TO QUIT?**

DO YOU USE ANY DRUGS? NEVER YES NO **QUIT DATE:** _____ **HAVE YOU EVER TRIED TO QUIT?** YES NO

NONE COCAINE/CRACK MARIJUANA HEROIN PRESCRIPTION DRUGS CRYSTAL METH OTHER

WHEN WAS YOUR LAST TUBERCUOSIS (TB) SKIN TEST? _____ **POSITIVE or NEGATIVE** (circle one)

WHEN WAS YOUR LAST TETANUS BOOSTER SHOT? _____

WHEN WAS YOUR LAST HIV / AIDS TEST? _____ **WOULD YOU LIKE TO KNOW HOW TO BE TESTED?** YES / NO

WOULD YOU LIKE A SUPPLY OF CONDOMS? YES NO **HAVE YOU BEEN TESTED FOR HEPATITIS?**_____

ARE THERE ANY HEALTH PROBLEMS *IN YOUR FAMILY*? (Circle any problems your family members have ever had)

ALCOHOLISM	DRUGS	BIPOLAR	DEPRESSION	HIGH BLOOD PRESSURE
HEART PROBLEMS	DIABETES	ASTHMA	KIDNEY PROBLEMS	COPD/EMPHYSEMA
SEIZURES	CHOLESTEROL	ARTHRITIS	BREAST CANCER	COLON CANCER

FOR WOMEN ONLY:

When was your last period? _____ **Last pap smear:** _____ **Have you ever had an *ABNORMAL* pap smear:** _____

How many pregnancies? _____ **How many children were born alive:** _____ **When was your last mammogram?** _____