# PATIENT REGISTRATION FORM

VECINO HEALTH CENTERS

## PATIENT INFORMATION - PLEASE PRINT

| LAST NAME | FIRST NAME | MIDDLE NAME | BIRTHDATE | GENDER |
|---|---|---|---|---|
| | | | | M F |

| SOCIAL SECURITY NUMBER | PHONE 1 | PHONE 2 | E-MAIL |
|---|---|---|---|
| | | | |

| ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

**RACE**
___ American Indian or Alaska Native
___ Asian
___ Native Hawaiian/Pacific Islander
___ Black/African-American
___ White
___ More than One Race
___ Unreported/Refused to Report

**ETHNICITY**
___ Hispanic/Latino
___ Not Hispanic/Latino
___ Unreported/Refuse

**LANGUAGE**
__ English
__ Spanish
__ Other

## INSURANCE INFORMATION – PLEASE PRINT

| PRIMARY INSURANCE NAME | ID # | GROUP # | POLICY HOLDER NAME |
|---|---|---|---|
| | | | |

| SECONDARY INSURANCE NAME | ID # | GROUP # | POLICY HOLDER NAME |
|---|---|---|---|
| | | | |

## GUARDIAN INFORMATION – PLEASE PRINT

| GUARDIAN 1 DOB | GUARDIAN 2 DOB |
|---|---|
| ADDRESS ___ SAME AS ABOVE | ADDRESS ___ SAME AS ABOVE |
| CITY/STATE/ZIP | CITY/STATE/ZIP |
| PHONE 1 / PHONE 2 | PHONE 1 / PHONE 2 |
| RELATIONSHIP<br>___Mother ___Father ___Other (specify)_____ | RELATIONSHIP<br>___Mother ___Father ___Other (specify)_____ |

## FAMILY SIZE/INCOME AS NOTED ON INCOME DOCUMENT(S) – PLEASE PRINT

| FAMILY SIZE | YEARLY INCOME | IF REFUSE, PLEASE INITIAL |
|---|---|---|
| | | |

## EMERGENCY CONTACT INFORMATION – PLEASE PRINT

| NAME | NAME |
|---|---|
| ADDRESS ___ SAME AS ABOVE | ADDRESS ___ SAME AS ABOVE |
| CITY/STATE/ZIP | CITY/STATE/ZIP |
| PHONE 1 / PHONE 2 | PHONE 1 / PHONE 2 |
| RELATIONSHIP<br>___Mother ___Father ___Other (specify)_____ | RELATIONSHIP<br>___Mother ___Father ___Other (specify)_____ |

| PATIENT OR AUTHORIZED SIGNATURE | PRINTED NAME | DATE |
|---|---|---|
| | | |

**How did you hear about us?** ___Newspaper ___TV ___Friend/Family ___Other (Specify) _____

VECINO
HEALTH CENTERS

## CONSENT FOR MEDICAL TREATMENT

Knowing that I, _____ am (is) suffering from a condition requiring diagnosis and medical treatment, I do hereby consent to such diagnostic procedures and hospital care and to such medical treatment as is necessary in the judgment of the Physician(s) of the medical staff of the Vecino Health Centers of Harris County, Texas who are agents or employees of the Vecino Health Centers.

I understand that if a healthcare worker is accidentally exposed to my blood or any body fluids in such a fashion that the healthcare worker may be at risk of contracting AIDS, I will be required to have my blood tested pursuant to Texas Law and hospital protocol to determine if I have Human Immunodefiency Virus (HIV) or other blood borne infections. Test results will be kept confidential to the extent allowed by law and any information concerning my identity in connection with such testing will be destroyed after notification of the healthcare worker who was exposed.

Signature:_____ Date: _____

Witness Signature:_____ Date: _____

## CONSENTIMIENTO PARA TRATAMIENTO MEDICO

Sabiendo que (ell nombre de la persona o yo) _____ estoy (esta) padeciendo de una condicion que requiere diagnostico y tratamientos necesarios, de acuerdo al juicio del medico y dental del Vecino Health Centers, Texas, quedes no son agentes o empleados del Vecino Health Centers.

Eri el caso que un profesional de la salud se exponga accidentalmente a mi sangre o fluidos corporales, se me ordenara un analisis de sangre para determinar si soy portador del virus del SIDA. Debido al riesgo potencial de contraer el Virus de Immunodeficiencia Humana u otras infecciones de la sangre , se solicita este analisis de acuerdo a la Ley del Estado de Texas y al protocolo hospitalario. Los resultados de estos analisis seran estrictamente confidenciales hasta donde la contempla la Ley.

Firma:_____ Fecha: _____

Testigo: _____ Fecha: _____

# Vecino Health Centers
## Consent for Treatment on Behalf of a Minor[1]

**Name of minor patient: _____ Date of Birth ____/____/____**

I_____ **(print the name of parent or legally authorized person**) hereby and voluntarily consent to authorize the physicians, mid-level providers (Physician Assistant, Advance Practice Nurse), and dentists, if available on the Center staff at their service locations to provide health care services to the above minor. The services may include routine physical and mental assessment, diagnostic and monitoring tests and procedures, immunizations, routine laboratory work, such as blood, urine, and other studies, x-rays and other imaging studies, heart tracing (EKG), administration of medications, as well as procedures and treatment prescribed by the medical and or dental staff.. The health care series also may include counseling services necessary to receive appropriate services including family planning services as defined by federal regulation. I understand that there are no guarantees being made to me concerning the results of the treatment or the effectiveness of any birth control methods prescribed for the minor.

I have received the "Patient and Center Rights and Responsibilities" and the "Notice of Patients Privacy Rights" and understand those documents. I certify that I fully understand this consent for treatment, use of midlevel providers, release of personal health information and the minor's rights concerning these issues. I understand that this consent is valid and remains in effect as long as the minor is a patient of the Center. I have been given an opportunity to ask questions about the services to be provided by this Center and I believe that I have sufficient information to give this consent.

**I am authorized to consent on behalf of the above minor as I am the minor's:**

□ Parent

□ Legal Guardian (specify relationship):

_____.

**A PICTURE ID WILL BE REQUIRED AT CHECK IN FOR THOSE PERSONS AUTHORIZED TO BRING THE CHILD IN. NO EXCEPTIONS**

**I authorize the following people to consent for medical treatment for my child in my absence:**

| Name | Relationship to child |
|---|---|
| _____. | _____. |
| _____. | _____. |
| _____. | _____. |
| _____. | _____. |

I understand that if someone who is not listed above brings the minor in for a visit, his/her appointment will/can be canceled.

_____ _____
Signature of Parent or Legal Guardian Witness Signature

_____ _____
Print Name Print Name

_____ _____
Date Time Date Time

_____

[1] *A minor is an individual who is unmarried and under 18 years of age, and has not had the disabilities of minority removed by the court*

VECINO
HEALTH CENTERS

# Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

□ Home Telephone _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ Written Communication
- □ O.K. to mail to my home address
- □ O.K. to mail to my work/office address
- □ O.K. to fax to this number

□ Work Telephone
- □ O.K. to leave message with disabled information
- □ Leave message with call-back number only

□ Other_____

_____ _____
Patient/Guardian Signature Date

_____ _____
Print Name of Patient Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

**Record of Disclosures of Protected Health Information**

| Date | Disclosed to Whom Address or Fax Number | 1 | Description of Disclosure/ Purposes of Disclosure | By Whom Disclosed | 2 | 3 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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| | | | | | | |
| | | | | | | |

**(1) Check this box if the disclosure is authorized**
**(2) Type Key: T=Treatment Records; P=Payment Information; O=Healthcare Operations**
**(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other**

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES**
***IMMUNIZATION REGISTRY (ImmTrac)***
**CONSENT FORM**

**DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD**
***REGISTRO DE INMUNIZACIÓN (ImmTrac)***
**FORMULARIO DE CONSENTIMIENTO**

***(Please print clearly** / Sirvase escribir claramente con letra de molde)*

**Child's Last Name** / Apellido del niño(a)

*For Clinic/Office Use*

**Child's First Name** / Nombre del niño(a)

**Child's Middle Name** / Segundo nombre del niño(a)

**Child's Date of Birth** / Fecha de nacimiento del niño(a)

***Children under 18 years only** / *Solamente niños menores de 18 años*

**Child's Gender** / Género: ☐ **Male** / Masculino ☐ **Female** / Femenino

**Child's Address** / Dirección del niño(a)

**Apartment #** / Apartamento #

**Telephone** / Teléfono

**City** / Ciudad

**State** / Estado **Zip Code** / Código postal

**County** / Municipio

**Mother's First Name** / Nombre de la madre

**Mother's Maiden Name** / Apellido de soltera de la madre

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

***The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.***

El registro de inmunización (ImmTrac) de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud. El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño (menor de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño será incluida en ImmTrac. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño para asegurar que las vacunas importantes no le falten.

***El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas.***

## Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that by granting consent below, I register my child in the Texas Department of State Health Services immunization registry and authorize the registry to include my child's information in the registry and to release past, present, and future immunization records on my child to a parent of the child and any of the following:

- public health district or local health department;
- physician or health care provider;
- insurance company, health maintenance organization or payor;
- school or child care facility in which the child is enrolled and/or
- state agency having legal custody of the child.

I understand that I may withdraw the consent to include information on my child in the ImmTrac Registry and my consent to release information from the registry at any time by written communication to the Texas Department of State Health Services, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

## Consentimiento Para Registrar al Niño(a) y Para Poder Dar a Conocer a Entidades Autorizadas el Récord de Inmunizaciones del Niño(a)

Entiendo y acepto que al autorizar mi consentimiento en la parte inferior, registro a mi niño(a) en el registro de inmunización del Departamento Estatal de Servicios de Salud de Texas y autorizo al registro para que incluya la información de mi niño(a) en el registro y que el récord de inmunizaciones de mi niño(a) del pasado, presente y futuro sea dado a conocer a alguno de los padres del niño(a), y a cualquiera de los siguientes:

- distrito de salud pública o departamento de salud local;
- médico o proveedor de atención de salud;
- compañía de seguros, organización para el mantenimiento de salud o pagador;
- escuela o centro de cuidado de niños, en el que el niño(a) está inscrito y/o
- agencia estatal que tenga custodia legal del niño.

Reconozco y acepto que en cualquier momento puedo retirar mi consentimiento de poder incluir la información de mi niño(a) en el Registro ImmTrac, y también retirar mi consentimiento para poder dar a conocer la información del registro, por medio de comunicación escrita dirigida al Texas Department of State Health Services, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

**By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.**
Al firmar abajo, YO **AUTORIZO el consentimiento** para registrarlo. Deseo **INCLUIR** la información de mi niño en el registro de inmunización de Texas.

**Parent, legal guardian, or managing conservator:**
Alguno de los padres, tutor legal o administrador de bienes:

**Printed Name** / Escriba con letra de molde

**Date** / Fecha

**Signature** / Firma

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.dshs.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code*, sección 552.021, 552.023, 559.003 y 559.004)

**Questions?** / **¿Tiene preguntas?** (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com Stock No. C-7

**Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347** Revised 07/17/07

***PROVIDERS REGISTERED WITH ImmTrac** – please fax this **signed** (by parent) Consent Form to ImmTrac **only if the child is not** currently registered with ImmTrac.*
***Fax to: Toll free (866) 624-0180***

# TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
# PATIENT ELIGIBILITY SCREENING RECORD

**CLINIC USE ONLY:**
TVFC Eligible:
☐ Yes ☐ No

Purpose: To determine eligibility and the source of funds for the Texas Department of State Health Services to be reimbursed for vaccines. A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: _____

Child's Name:

_____
Last Name First Name MI

Child's Date of Birth: ____/____/____
mm/dd/yy

Parent/Guardian/Individual of Record:

_____
Last Name First Name MI

Provider's/Clinic's Name:

_____

**The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check the first category that applies, check only one):**

- ☐ (a) is enrolled in Medicaid, or
- ☐ (b) does not have health insurance, or
- ☐ (c) is an American Indian, or
- ☐ (d) is an Alaskan Native, or
- ☐ (e) is underinsured (has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage), or
- ☐ (f) is a patient who is served by any type of public health clinic and does not meet any of the above criteria, or
- ☐ (g) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP)
- ☐ **None of the above, not eligible for TVFC vaccine**

Signature: _____ Date: _____

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock No. C-10
Revised 04/06

VECINO
HEALTH CENTERS

I, _____, have received Houston Community Health Centers, Inc.'s policy on Patient Rights & Responsibilities and Notice of Client Rights (attached). By signing this, I am fully aware of both documents and agree to follow the rules of the clinic as they are written in these documents.

_____ _____

Patient/Guardian Signature Date

**OFFICE USE ONLY**

_____ _____

Employee Signature Date

**PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES**

Name: _____ Date of Birth: ____/____/____ MR#: _____

**Welcome to the center.**

Whether you're seeking wellness, recovering from illness or managing a chronic condition. It's a cycle of staying well, getting well and being well. If you deal with health situations in a long-term relationship with a trusted medical, dental, or behavioral health provider, then you've found your Patient Centered Medical Home here with us.

Our goal is to provide quality health care to people in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. The center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read and sign this statement and ask us questions you might have.

**A. Human Rights**

You have a right to be treated with respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age, Vietnam era veteran status, or other grounds consistent with applicable federal, state and local laws and regulations.

**B. Payment For Services**

1. You are responsible for giving staff accurate information about your present financial status and any changes in your financial status. The staff need this information to determine if you qualify for Vecino financial assistance program (FAP) and/or so they can bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, you will be charged a discounted fee.
2. You have a right to receive explanations of the center's charges. You must pay, or arrange to pay, all agreed fees for medical and behavioral health services. Dental services, are provided on a prepaid basis. If you cannot pay right away, please let staff know so they can provide care for you now and work out a payment plan. Federal law[1] prohibits the center from denying you primary health care services which are medically necessary solely because you cannot pay for these services.

[1] For more on the Sliding Fee Scale see chapter 9 of the Health Center Compliance Manual and the relevant Sliding Fee Discount Program protocol in the Health Center Program Site Visit Protocol. Last accessed March 2018.

## C. Privacy

You have a right to have your interviews, examinations, and treatment in privacy. Your medical records are also private. Only legally authorized persons may see your medical records unless you request in writing for us to show them to, or copy them for, someone else. In certain instances, the center may be required to report to the Texas Department of State Health Services regarding your health condition or disease status. A complete discussion of your privacy rights will be given to you along with this document and is named the center's Notice of Privacy Practices. Staff will request that you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices sets forth the ways in which your medical records may be used or disclosed by the center and the rights granted to you under the Health Insurance Portability and Accountability Act ("HIPAA").

## D. Health Care[2]

1. You are responsible for providing the center complete and current information about your health or illness, so that we can give you proper health care. You have a right, and are encouraged, to participate in decisions about your treatment.

2. You have a right to information and explanations in the language you normally speak and in words that you understand. You have a right to information about your health or illness, treatment plan, including the nature of your treatment, its expected benefits, its inherent risks and hazards (and the consequences of refusing treatment), the reasonable alternatives, if any (and their risks and benefits), and the expected outcome, if known. This information is called obtaining your informed consent.

3. You have the right to receive information regarding "Advance Directives." "Advance Directives" are instructions you provide for medical care in the event you become unable to communicate your wishes. If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to your legally authorized representative.

4. You are responsible for appropriate use of center services, which includes following staff instructions, making and keeping scheduled appointments, and requesting a "walk in" appointment only when you are ill. Center professionals may not be able to see you unless you have an appointment. If you are unable to follow instructions from the staff, please tell them so they can help you.

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[2] This policy and procedure is designed to be consistent with the intent of the requirements for the Joint Commission Standards RI.01.01.01, RI.01.01.03, RI. 01.02.01, RI.01.03.01, CAMAC Update 1, July 2017.

5. If you are an adult, you have a right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of your refusing such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed." You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in your best interest, you may be asked to sign a Refusal to Permit Medical Treatment or Services form or Against Medical Advice form (as appropriate).

6. You have a right to health care and treatment that is reasonable for your condition and within our capability, however, the center is not an emergency care facility. You have a right to be transferred or referred to another facility for services that the center cannot provide. The center does not pay for services that you receive from another healthcare provider

7. If you are in pain, you have a right to receive an appropriate assessment and pain management, as necessary.

**E. <u>Center Rules</u>**

1. You have a right to receive information on how to appropriately use the center's services. you are responsible for using the center's services in an appropriate manner. If you have any questions, please ask us.

2. You are responsible for the supervision of children you bring with you to the center. You are responsible for your children's safety and the protection of other patients and our property.

3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments, you may be subject to disciplinary action pursuant to the center's policies and procedures.

**F. <u>Complaints</u>**

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Staff will tell you how to file a complaint. If you are not satisfied with how the staff handles your complaint, you may complain to the center's Board of Directors.

2. If you make a complaint, no center representative will punish, discriminate, or retaliate against you for filing a complaint, and the center will continue to provide you services.

## G. Termination

If the center decides that we must stop treating you as a patient, you have a right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find other health care services. However, the center can decide to stop treating you immediately, and without written notice, if you have created a threat to the safety of the staff and/or other patients. You have a right to receive a copy of the center's Termination of the Patient and Center Relationship Policy and Procedure.

Reasons for which we may stop seeing you include:

1. Failure to obey center rules and policies, including but not limited to failure to keep scheduled appointments, using abusive language, or displaying disrespectful behavior.
2. Intentional failure to accurately report your financial status.
3. Intentional failure to report accurate information concerning your health or illness.
4. . Intentional failure to follow the health care program, such instructions about taking medications, personal health practices, or follow up appointments, as recommended by your healthcare provider(s), and/or
5. Creating a threat to the safety of the staff and/or other patients.

## F. Appeals

If the center has given you notice of termination of the patient and center relationship, you have the right to appeal the decision to the Board. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

By: _____ _____/_____/____

Name: _____ Date

[Print Name]

If signing for a minor, _____

[Print Minors Name]