

PATIENT REGISTRATION FORM



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 ___ Mother ___ Father ___ Other (specify) _____		RELATIONSHIP ___ Mother ___ Father ___ Other (specify) _____	

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

FAMILY SIZE	YEARLY INCOME	IF REFUSE, PLEASE INITIAL
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EMERGENCY CONTACT INFORMATION – PLEASE PRINT

NAME	NAME
ADDRESS	ADDRESS
CITY/STATE/ZIP	CITY/STATE/ZIP
PHONE 1	PHONE 2
RELATIONSHIP ___ Mother ___ Father ___ Other (specify) _____	RELATIONSHIP ___ Mother ___ Father ___ Other (specify) _____

PATIENT OR AUTHORIZED SIGNATURE	PRINTED NAME	DATE
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How did you hear about us? ___Newspaper ___TV ___Friend/Family ___Other (Specify) _____



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 Immunodeficiency 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 (el 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 Inmunodeficiencia 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: _____



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):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax to this number |
| <input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with disabled information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> 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

(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



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 law¹ 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 Care²

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.

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. Center Rules

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. Complaints

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]