Patient Registration Form

We do not discriminate against any person on the basis of race, color, national origin, sex, age, religion, or disability, in our programs and services

Patient Information

Please provide your photo ID to the Receptionist

Last Name: First Name:

Date of Birth: SSN: Primary Language:

Gender: ☐ Male ☐ Female ☐ _____ Transgendered: ☐ Yes

Mailing Address: _____

Physical Address:

Home Phone: Work Phone: ext:

Cell Phone: E-mail Address:

We may contact you through the above communication methods for appointment and general health reminders unless you indicate a method(s) you prefer we not use:

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown

Race: *- Check all that apply*
☐ White (includes Hispanic or Latino) ☐ Black or African American ☐ American Indian / Alaska
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Insurance or Payment Source

Please provide your Insurance Card(s) to the Receptionist

☐ Medicaid ☐ CHIP ☐ Medicare ☐ Private Pay (self-pay) ☐ Other _____

☐ Commercial Insurance - *Name:* _____ ☐ Medicare with Supplement Insurance - *Name:* _____

Employment Status

☐ Full-time ☐ Self Employed ☐ Retired ☐ Active Duty Military

☐ Part-time ☐ Not Employed ☐ Veteran

Responsible Party

☐ Self (*patient listed above*) ☐ Guarantor; please complete the following details: _____

Last Name: First Name:

Date of Birth: Relationship to patient:

Address: _____

Best Contact Telephone Number: ☐ Home ☐ Cell ☐ Work

Emergency Contact

Last Name: First Name:

Home Phone: Work Phone: ext:

Cell Phone: Relationship to patient:

Preferred Pharmacy:

Pharmacy Name: _____

Address: _____

_____

Advanced Directive:

Do you have an Advanced Directive on file? ☐ Yes ☐ No

If yes, please provide us a copy. Note that if we do not have a copy on file, we will follow the medical standard of care. If no, you can find out more information at: https://texaslawhelp.org/article/advance-directives

☐ I acknowledge my responsibility to pay for services rendered and understand that I will be responsible for any fees that are not paid by my Insurance or covered by HealthPoint programs.

Please initial

HealthPOINT
GENERAL CONSENT FOR TREATMENT

The information in this consent form outlines your rights, as our patient, to be informed about your condition and the recommended medical or diagnostic procedures your provider may use throughout the course of your relationship with HealthPoint.

I, _____,
(PATIENT'S PRINTED NAME)

born on _____/_____/_____,
(PATIENT'S DATE OF BIRTH)
consent to and request that my health care provider, along with any necessary staff, perform reasonable and necessary medical examinations, tests, and treatments for the purpose of assessing and managing any conditions or illnesses that I currently have or may develop.

I understand that HealthPoint is a primary care clinic that focuses on preventative healthcare. I acknowledge that only a limited number of these primary care examinations, tests, or treatments require disclosure of specific risks, as required by the Texas Medical Disclosure Panel; should my health care provider recommend a treatment that requires disclosure of specific risks, I will be asked to sign additional documents indicating that I have been advised of the specific risks and hazards of the recommended procedure or treatment.

I understand there are certain risks or hazards associated with any form of treatment or test, and that I have not been made any guarantee about a result or cure from any treatment or test provided by HealthPoint or its staff. I further acknowledge that HealthPoint does not assume any responsibility, financial or otherwise, for services or care received outside of HealthPoint.

I acknowledge that minimally necessary information may be released by HealthPoint in order to comply with Federal and State law, including the Health Insurance Portability and Accountability Act of 1996 and the Texas Medical Records Privacy Act. Additionally, limited information may be released to certain Federal and State agencies that provide funding to HealthPoint in order to ensure compliance with legal responsibilities.

I understand that HealthPoint is a federally deemed facility under the Federal Torts Claims Act, meaning that HealthPoint is considered a part of the federal government for the purposes of civil liability.

This consent will remain in effect until I withdraw my consent. If HealthPoint changes the nature of its services, or it has been at least two years since my last appointment, I will be asked complete another general consent for treatment.

I have been given the opportunity to ask questions regarding this consent, and I certify that this form has been fully explained to me and that I understand its contents.

_____
SIGNATURE OF PATIENT *OR OTHER LEGALLY AUTHORIZED PERSON*

_____
NAME OF OTHER LEGALLY AUTHORIZED PERSON (if applicable)

_____
RELATIONSHIP OF OTHER LEGALLY AUTHORIZED PERSON TO PATIENT (if applicable)

_____/_____/_____
TODAY'S DATE

Third Party Information Release & Consent

Please read this entire form before signing and complete all sections that apply to your decisions relating to the disclosure of protected health information (PHI). This clinic is required by federal and state law to obtain a signed authorization from the patient (or patient's legally authorized representative) to disclose that patient's PHI. As indicated below, specific authorization is required for the release of information about certain sensitive conditions, including: mental health records; drug alcohol, or substance abuse records; records relating to HIV/AIDS; genetic (inherited) diseases or tests). This form is NOT required for the permissible disclosure of an individual's PHI to themselves or the patient's legally authorized representative. However, such access may be limited by physician or mental health provider if determined to be harmful to the patient's physical, mental, or emotional health.

EFFECTIVE TIME PERIOD. This authorization is valid until either the occurrence of the death of the patient or permission is withdrawn.

RIGHT TO REVOKE. One can withdraw permission at any time by giving written notice revoking this authorization to the person or organization named herein.

SIGNATURE OF PATIENT OR AUTHORIZED INDIVIDUAL

_____

DATE _____ **ACCOUNT NUMBER**_____

SIGNATURE AUTHORIZATION. I have read this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

I authorize the BRAZOS VALLEY COMMUNITY ACTION AGENCY, INC. dba HEALTHPOINT to disclose my protected health information to the following individual/organization:

Individual/Organization Name _____

Address _____

City _____ *State* _____ *Zip Code* _____

Phone (_____)_____ *Fax* (_____)_____

WHAT INFORMATION CAN BE DISCLOSED TO THIS INDIVIDUAL/ORGANIZATION? (Check all that apply):

□ ALL HEALTH INFORMATION	□ History /Exams/Progress Notes	□ Lab results
□ Reports & Images	□ Medications & Allergies	□ Physician's orders
□ Billing information	□ Appointment information	□ Other _____

Your initials are required to release the following information:

_____Mental health records (excluding psychotherapy notes) _____Genetic information (including genetic test results)

_____Drug, alcohol, or substance abuse records _____HIV/AIDS test results/treatment

Complete the following section ONLY IF THE PATIENT IS A MINOR (i.e., under the age of 18) or a LEGALLY NON-COMPETENT adult AND you are the parent/legal guardian of the patient:

Does the above-listed, non-parent individual/organization have authorization to consent to medical treatment (immunization excepted) for the patient?

If YES, please initial in the following blank: _____

PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES

Patient's Name: _____

Date of Birth: _____/_____/_____

Welcome to HealthPoint

Our goal is to provide the highest quality health care that is both affordable and accessible to all. 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.

Your Rights as Our Patient

- **Nondiscrimination**

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

- **Payment**

While all patients of federally qualified health centers are expected to financially participate in their health visits, you will not be denied services due to an inability to pay at the time of the visit. The clinic can assist you by screening you for eligibility to participate in various state and federal programs that pay for some or all of your health visits, as well as providing options for payment plans.

You have the right to receive explanations about the bill you received from the clinic.

- **Privacy**

You have the right for your interviews, examinations, and treatment to be conducted in privacy. Your medical records are also private.

You have the right to receive a complete discussion of your privacy rights as our patient in the form of our "Notice of Patient Privacy Rights"; this document provides a comprehensive review of the ways in which we may use or disclose your medical records. By signing the "Patient and Center Rights and Responsibilities" you are acknowledging that you have received and understood our "Notice of Patient Privacy Rights."

- **Health Care**

You have the right, and are encouraged, to participate in decisions about your treatment.

You have the right to information about your health or illness, and your 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. After being informed of this information and providing your consent, you are giving us what is known as "informed consent."

You have the right to information and explanations in the language you normally speak and in words that you understand.

You have the right to receive information regarding "Advance Directives." 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.

If you are an adult, you have the right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. 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 have the 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.

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

- **Center Rules**

You have the right to receive information on how to appropriately use the center's services. If you have any questions, please ask us.

If the center decides that we must stop treating you as a patient, you have the right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find another primary care provider.

You have the right to receive a copy of the center's "Noncompliance and Termination" Policy and Procedure.

If the center has given you notice of termination, you have the right to appeal the decision to the Medical Director.

- **Complaints**

You have the right to tell us how we can improve the services that we offer you. Staff will tell you how to make a suggestion or file a complaint. If you are not satisfied with how the staff handles your situation, you may contact the center's administration.

Although we encourage you to bring your concerns directly to us, you always have the right to take any complaint to the Texas Department of State Health Services or Health and Human Services.

Your Responsibilities as Our Patient

- **Payment**

You have the responsibility to give staff accurate information about your present insurance and/or financial status, as well as any changes in your insurance and/or financial status. The staff need this information to determine your financial responsibility and/or so they can bill private insurance, Medicaid, Medicare, or determine other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, you will be charged a nominal fee.

You have the responsibility to pay, or arrange to pay, all agreed fees for medical and dental services. If you cannot pay right away, please let staff know so arrangements can be made.

- **Privacy**

You have the responsibility of informing us of the people, if any, that may or may not access your medical records. It is important that we know this information from the beginning of your relationship with us so that we can avoid any future confusion. Staff can provide you a form to indicate those people you are granting access to your private medical record.

If you are a parent or legal guardian, please let staff know if someone other than yourself or the child's legal guardian may be bringing the child to receive services.

- **Health Care**

You have the responsibility for providing the center complete and current information about your health or illness, so that we can give you proper health care.

You have the responsibility for assuming the consequences and outcomes 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 the center's "Patient Declination of Care" form.

You are responsible for appropriate use of center services, which includes following staff instructions, and making and keeping scheduled appointments. Center professionals may not be able to see you unless you have an appointment.

- **Center Rules**

You have the responsibility to use the center's services in an appropriate manner – this means you must conduct yourself respectfully to all staff and fellow patients at all times while you are accessing clinical services. Threatening, abusive, violent, fraudulent, intentionally offensive, or any unlawful behavior will not be tolerated. If your behavior is deemed to consistently or permanently disrupt the relationship between your healthcare provider and yourself, then your relationship to the center may be terminated pursuant to the center's policies and procedures.

You have the responsibility to supervise the children that you bring with you to the center.

You have the responsibility for your children's safety, and the protection of other patients and our property.

You have the responsibility to keep your scheduled appointments. Missing scheduled appointments causes delay in treating other patients. If you do not keep scheduled appointments and/or fail to provide timely notification to the center, pursuant to the center's policies and procedures you may lose the privilege to schedule future appointments.

HealthPoint's Rights as Your Provider

- **Privacy**

In certain instances, HealthPoint may be required to disclose your medical records to State or Federal agencies for the purposes of mandatory reporting or investigations.

The center may also be compelled to disclose your medical records pursuant to a valid court order.

- **Center Rules**

HealthPoint has the right to stop treating you as a patient if you commit a substantial violation of the center's rules.

HealthPoint has the right terminate its relationship to you immediately and without written warning if you create a threat to the safety of the center's staff or other patients.

HealthPoint's Responsibilities as Your Provider

- **Generally**

HealthPoint has the responsibility to ensure that you are provided with quality care in an environment that protects and promotes your rights as our patient.

- **Complaints**

HealthPoint has the responsibility to ensure that no center representative will punish, discriminate, or retaliate against you for filing a complaint, and the center will continue to provide you services.

_____

SIGNATURE OF PATIENT *OR OTHER LEGALLY AUTHORIZED PERSON*

_____

NAME OF OTHER LEGALLY AUTHORIZED PERSON (if applicable)

_____

RELATIONSHIP OF OTHER LEGALLY AUTHORIZED PERSON TO PATIENT (if applicable)

_____/_____/_____

TODAY'S DATE

Created: 12/19/2018
Revised: 12/19/2018