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

HealthPOINT

THIRD PARTY ACCESS & 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). The purpose of this form is to allow you, as our patient, to designate other individuals to assist with your care by allowing HealthPoint staff to discuss or release information about your general health, treatment plan, and/or recommendations. **EFFECTIVE TIME PERIOD**: This authorization is valid until either the death of the patient, permission is withdrawn, or until a specified date (optional). You can withdraw your permission at any time by completing the last section of this form.

PATIENT NAME: ____
Last First Middle

DATE OF BIRTH: ____
Month Day Year

I authorize HealthPoint to disclose my protected health information to the following individual/organization:

Individual/Organization Name ____

Address ____

City ____________________________________ *State* ________________ *Zip Code* _________________

Phone (________)______________________________ *Fax* (________)_____________________________

If there is any information that you DO NOT WANT released to this individual/organization, please indicated below:

☐ History/physical exam ☐ Consult notes ☐ Past/present medications ☐ Allergies

☐ Lab results ☐ Radiology reports & images ☐ Billing information

☐ Diagnostic test reports ☐ ALL RECORDS ☐ Other____

Your initials are REQUIRED to release the following information to this individual/organization:

___________ Mental health records ___________ Genetic information (including genetic test results)

___________ Substance use disorder records ___________ HIV/AIDS test results/treatment

CONSENT FOR MINORS: Initial below this section if the patient is A MINOR (i.e., under the age of 18) and, you, as the minor's parent/legal guardian, would like to allow the above-listed individual to consent to THE MINOR'S treatment if you are not present for the minor's appointment.
CONSENT FOR ADULTS: Initial below this section if you, as our patient, would like to allow the above-listed individual to consent to your treatment if you become INCAPACITATED (i.e., unable to understand the consequences of treatment decisions).

If **YES**, please initial in the blank: _____________

I have read this form and agree to the uses and disclosures of my PHI as described. I understand that HealthPoint is not liable for the uses and disclosures of your PHI made by the recipient.

SIGNATURE: ____ **TODAY'S DATE:** ___________________________
Signature of Patient (or Legally Authorized Representative)

Printed name of Legally Authorized Representative (if applicable): ____

If a representative, specify relationship to the patient: ☐ *Parent* ☐ *Guardian* ☐ *Other (specify)* ___________________

REVOCATION:
If you wish to REVOKE this consent for any reason, please sign and date below:

Signature: ______________________________________ *Date*: ____________________

Created: 12.19.2018
Revised: 10.3.2023

(A dba of Brazos Valley Community Action Agency, Inc.)

PATIENT AND HEALTHPOINT RIGHTS AND RESPONSIBILITIES

Patient 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. HealthPoint also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better healthcare for you. Please read and sign this statement and ask us any questions you might have.

Your Rights as a HealthPoint 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 and regulations.

Payment

While all patients of federally qualified health centers are expected to financially participate in their heath visits, HealthPoint offers eligibility screening for various state and federal programs that assist with health visit cost. Patients who are at or below 200% of the federal poverty guidelines and are deemed eligible will be informed of their appropriate office visit nominal fee at the time of eligibility.

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 HealthPoint 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, HealthPoint is not an emergency care facility. You have the right to be transferred or referred to another facility for services that HealthPoint cannot provide. HealthPoint does not pay for services that your receive from another healthcare provider.

PATIENT AND HEALTHPOINT RIGHTS AND RESPONSIBILITIES

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

HealthPoint Rules

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

You have the right to receive HealthPoint's "Noncompliance and Termination Policy and Procedure," as you are expected to follow it.

You have the right to receive HealthPoint's "No Show Policy," as you are expected to follow it.

If HealthPoint 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.
If HealthPoint has given you notice of termination, you have the right to appeal the decision to the Chief Medical Officer.

Complaints

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

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

Your Responsibilities as HealthPoint Patients

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. HealthPoint staff needs this information to determine your financial responsibility and/or so they can bill private insurance, Medicaid, Medicare, or determine other benefits for which you might be eligible. If your income is less than the federal poverty guidelines, you could 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 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. HealthPoint 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 child's legal guardian may be bringing the child to receive services.

Health Care

You have the responsibility for providing HealthPoint 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 re recommended treatment or procedure. If you refuse treatment or procedures that your healthcare provider believes is in your best interest, you may be asked to sign HealthPoint's "Patient Declination of Care" for.

You are responsible for appropriate use of HealthPoint's services, which include the

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PATIENT AND HEALTHPOINT RIGHTS AND RESPONSIBILITIES

following staff instructions, making and keeping scheduled appointments.

You are responsible for following HealthPoint's "No Show Policy."
HealthPoint professionals may not be able to see you unless you have an appointment.

HealthPoint Rules

You have the responsibility to use HealthPoint'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 HealthPoint may be terminated pursuant to HealthPoint's policies and procedures.

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

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

You have the reasonability to keep your scheduled appointments. Missed scheduled appointments cause delays in treating other patients. If you do not keep scheduled appointments and/or fail to provide timely notification to HealthPoint, pursuant to HealthPoint's policies and procedures, you may lose the privilege to schedule future appointments. You can read more about HealthPoint's "No Show Policy" here.

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

HealthPoint Rules

HealthPoint has the right to stoop treating you as a patient if you commit a substantial violation of HealthPoint's rules.
HealthPoint has the right to terminate its relationship with you immediately and without written warning if you create a threat to the safety of HealthPoint'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 in environment that protects and promotes your rights as our patients.

Complaints

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

____

Patient's Signature or Signature of Responsible Party

____

Patient's Name or Name of Responsible Party (if applicable)

____

Relationship to Patient (if applicable)

____

Today's Date