

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 <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander		ETHNICITY <input type="checkbox"/> Black/African-American <input type="checkbox"/> White <input type="checkbox"/> More than One Race <input type="checkbox"/> Unreported/Refused to Report		LANGUAGE <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported/Refuse <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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		GUARDIAN 2		DOB
ADDRESS		ADDRESS		DOB
CITY/STATE/ZIP		CITY/STATE/ZIP		
PHONE 1	PHONE 2	PHONE 1	PHONE 2	
RELATIONSHIP		RELATIONSHIP		
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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		ADDRESS		
CITY/STATE/ZIP		CITY/STATE/ZIP		
PHONE 1	PHONE 2	PHONE 1	PHONE 2	
RELATIONSHIP		RELATIONSHIP		
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (specify) _____		
PATIENT OR AUTHORIZED SIGNATURE		PRINTED NAME		DATE

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: _____

Vecino Health Centers
Consent for Treatment on Behalf of a Minor¹

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
_____	_____
Name	Relationship to child
_____	_____
Name	Relationship to child
_____	_____
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



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
- Work Telephone _____
 - O.K. to leave message with disabled 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
- 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
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VECINO HEALTH CENTERS PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES

Welcome to Vecino Health Centers.

Our goal is to provide high quality health care services to qualified persons in this community, regardless of their ability to pay. If the Center is enrolling new patients, you may be eligible to become our patient. As a patient, you have rights and responsibilities. Vecino Health Centers 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.

Human Rights:

You have a right to be treated with respect and dignity regardless of race, religion, sex, national origin, sexual orientation, political affiliation, or ability to pay for services.

Payment for Services:

- You are responsible for giving us accurate information about your present financial status and any changes in your financial status. We need this information to decide how much to charge you and/or so we 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.
- You have a right to receive explanations of our bill. You must pay, or arrange to pay, all agreed fees for services, with the exception of dental services, which are provided on a prepaid basis. If you cannot pay right away, please let us know so we can provide care for you now and work out a payment plan.
- Federal law prohibits us from denying you primary health care services which are medically necessary, solely because you cannot pay for these services.

Privacy:

You have a right to have your interviews, examinations and treatment in privacy. Your health care records are also private. Only legally authorized persons may see your records unless you request in writing for us to show them to someone else. A complete discussion of your privacy rights is attached as "Notice of Client Privacy Rights." The Notice details the various rights granted to you by the Health Insurance Portability and Accountability Act.

Health Care:

- You are responsible for providing us 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.
- 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 risks) and expected outcome, if known, and 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 a legally authorized person.

- You are responsible for appropriate use of our services, which includes following our staff's instructions, making and keeping scheduled appointments. Walk-in appointments are strongly discouraged. If you cannot follow the staff's instructions, please tell us so we can help you.
- If you are an adult, you have a right to refuse treatment to the extent permitted by law and to be informed of the risks of refusing such care. You are responsible for the outcome of refusing treatment.
- You have a right to health care and treatment that is reasonable for your condition and within our capability.
- You have a right to be transferred or referred to another facility for services that we cannot provide. But, we do not pay for services that you get somewhere else. Vecino Health Centers is not an emergency care facility.
- If you are in pain, you have a right to receive an appropriate assessment and management, as necessary.

VECINO HEALTH CENTERS Rules:

- You have a right to receive information on how to appropriately use Vecino Health Centers services. You are responsible for using Vecino Health Centers services in an appropriate manner. If you have questions, please ask us.
- You are responsible for the supervision of children you bring with you to Vecino Health Centers. Unattended minors are not allowed in the waiting room or any area of the clinic. ***You are responsible for their safety and the protection of clients and our property. The clinic staff may contact the police or child protective services if unattended children are found on Vecino Health Centers property.***
- You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. When you accrue your 1st and 2nd missed scheduled appointments, the Center will send to your home a "Notice of Non-Compliance Form" to make you aware of your no show missed appointments. When you have missed your 3rd scheduled appointment, Vecino Health Centers may then send you a termination letter. If you wish, you may speak with the Executive Director or Medical Director to dispute the decision of termination. Please call the Center and schedule an appointment with them.

Complaints:

- If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. We will tell you how to file a complaint. If you are not satisfied with how we handle your complaint, you may complain to the Board of Directors.
- If you complain, we will not punish you for filing a complaint and we will continue to provide services.
- Please call the Customer Service Line at 713-343-5460 for complaints

Termination:

If we decide that we must stop treating you as a patient, you have a right to advance notice that explains the reason for the decision, and you will be given 30 days to find other health care services. We can decide to stop treating you immediately and without notice if you have created a threat to the safety of the staff and/or other clients. You have a right to receive a copy of the Center's termination of the Patient and Vecino Health Centers Relationship policy.

Reasons for which we may stop seeing you include (but are not limited to):

1. Failure to obey our rules, such as keeping scheduled appointments
2. Intentional failure to report accurately 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 provider.
5. Creating a threat to the safety of the staff and/or other clients

If we have given you notice of termination of the patient and Vecino Health Centers relationship, you have the right to appeal the decision to the CEO/Medical Director. While you are appealing our decision, we will see you as a patient on an emergency basis only.



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