PATIENT REGISTRATION FORM

(Please Print Clearly)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑Hispanic/ Latino	❑White	❑Asian	❑African American
			❑Pacific Islander	❑American Indian	❑More than one race	❑Unknown

Have you ever used another name? ❑ Yes ❑ No	List other names you have used	Birth date: / /	Age:	Sex: ❑M ❑ F

Street address:	Apt:	Social Security no.:	Home phone no.: ( )

County:	City:	State:	ZIP Code:

Primary Language: ❑ English ❑Spanish ❑ Other ______________	Are you a veteran of the U.S. Armed Forces? ❑Yes ❑No	Marital status (circle one) Single / Mar / Div / Sep / Wid

If the child is under 18 and receiveing vaccines please fill out the following:	Mother's First Name	Mother's Maiden Name	Birth Date: / /

Chose clinic because/Referred to clinic by (please check one box):					❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Church	❑ Internet	❑ Walk In	❑Newspaper	❑ School	❑ Outside Signage

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No (If you checked 'No' please skip this section)

Please indicate primary insurance:	❑ Medicaid	❑ Medicare	❑ CHIP	❑ CHIP Perinatal
❑ Private Insurance:	❑ Other			

Person responsible for charges:	Birth date: / /	Address (if different):	Home phone no.: ( )

Employer:	Employer phone no.: ( )		

Policy Holder:	Patient's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary Insurance:	Subscriber's S.S. no.:	Subscriber's name:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

FOR OFFICE USE ONLY

MR#: ______________________ Reviewed by: ______________________ Date: __________ Initial: ______

PAYMENT POLICY

The Spring Branch Community Health Center is a private and not for profit clinic. Standard charges have been established for all services provided. We are not a County or City Clinic. Any additional costs including labs and X-rays will be an extra cost on the patient.

If you have Medicaid or Medicare the charges for your visit and the services received will be submitted to Medicaid /Medicare for reimbursement to the clinic. Please be sure to bring your current Medicare/Medicaid certification letter with you each time you visit the center.

If you do not have Medicaid/Medicare, you will be charged based on the total family income and the number of people in your household.

I authorize my insurance benefits be paid directly to the health center. I understand that I am financially responsible for any balance due. I also authorize SBCHC or insurance company to release any information required to process my claims.

I have read and I understand the payment information.

____   _________________________
Patient/Guardian signature (if patient is under 18)   *Date*

CONSENT FOR MEDICAL TREATMENT

I agree to have medical care provided by Spring Branch Community Health Center providers, and to follow their instructions regarding appointments and testing which may be required.

I understand that my medical information is confidential and protected to the extent of the law. My medical records are confidential and are released with my own written consent. I hereby consent for medical care and treatment at the Spring Branch Community Health Center.

I do not hold the Clinic or its employees responsible for any unusual effects resulting from their care.

I certify that I have read and understand the HIPPA Notice of Privacy Practices and understand my rights as a patient.

____   _________________________
Patient/Guardian signature (if patient is under 18)   *Date*

SLIDING FEE DISCOUNT

Immediate family members

Monthly Income: $

Number of people living in household: #

Last Name	First	Relation to head of household	Sex (M/F)	Social Security #	Date of Birth	Income
					/ /	
					/ /	
					/ /	
					/ /	
					/ /	
					/ /	

OFFICE USE ONLY

Documentation Collected:	❑Photo I.D.	❑Copies of last 3 paychecks	❑Copy of income tax return	❑Welfare Coupons		
❑Social Security/Retirement	❑Alimony	❑Stipends	❑Child Support	❑ Workman's Compensation	❑Homeless	❑Other

❑Homeless ❑Vaccines ❑Pregnancy Test ❑Lab work

Monthly Income: ______________ Family Size #: __________ Federal Poverty Level: ______________

The patient ________________________________ has been approved to receive benefits under the SBCHC sliding fee scale based on the information they have provided to us. The patient will pay $ ______________ at every office visit.

____   _________________________
SBCHC authorized signature   Date

Notice of Client Privacy Rights

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice applies to all of the records of your care generated by this Center, whether made by the Center or an associated provider. Our policies on protecting your health information extend to all professional authorized persons who have a need to know to provide care to you. The policies apply to all areas of the Center including all Center staff, the front desk, billing and administration. It also applies to any entity or individual with whom we contract services, such as referral providers.

YOUR PROTECTED HEALTH INFORMATION

As our patient, we create paper and electronic medical records and documents concerning you and your health, as well as the care and services we provide to you. We need this record to provide continuity of care and to comply with certain legal requirements. We are required by law to:

▪ Make sure that your protected health information is kept private.

▪Provide you with this Notice of Client Privacy Rights

▪Make sure the law and your legal rights are in effect.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

Treatment: We use information previously compiled about you to provide with current or future health care treatment or services. Therefore, we may, and most likely will, disclose your information to doctors, nurses and other health care personnel who are involved in your care.

Payment: We may use and disclose medical information about your concerning services and procedures so they may be billed and collected from you, your insurance company or third party reimbursement entity such as Workers Compensation.

Operational Uses: We may use and disclose medical information about you in order to operate the Center efficiently and make sure our patients receive quality of care.

Appointment and Patient Recall Reminders: We may use and disclose your health information to contact you to remind you regarding appointments or for medical care that you are to receive.

External Entities: In an emergency we may disclose information about you to an entity assisting in disaster relief so that your family can be notified about your condition, status and location.

Research: We may participate in research concerning the use of certain treatment protocols that have proper governmental and Center approval. In that case, we would secure your informed consent that will identify all aspects of you involvement, risks and benefits and possible disclosures.

Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose your health information to persons who need to know when necessary to prevent a serious threat to either your health or the health and safety of others.

Organ and Tissue Donation: If you are an organ donor, we may disclose medical information to organizations that handle organ procurement and transplantation.

Public Health Issues and Risks: We may report your health information as required by la or by your authorization concerning certain health conditions to prevent or control disease, injury or disability, births and deaths, child or elder abuse or neglect, reactions to medications or products, recalls of products, and notice of exposure to a condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your health information to law enforcement, social services, or other government agencies authorized to receive the report if we have reason to believe that you are a victim of abuse, neglect, or domestic violence.

Investigations and Government Activities: We may disclose your health information to a local, state or federal agency for oversight activities authorized by law that may concern inspections, licensure, illegal conduct, or compliance with other laws and regulations including civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose your health information in response to a subpoena, court subpoena or court order, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement: We may release your health information to law enforcement officials in response to a court order, subpoena, warrant, summons or similar process, to identify or locate a suspect witness or missing person, concerning a victim of a crime, about a death we believe may involve criminal actions, criminal conduct in progress, crimes on Center premises, or emergency situations to report a crime or details of a crime.
Coroners, Medical Examiners and Funeral Directors: We may release your health information to a coroner or medical examiner or funeral directors as necessary for them to carry out their duties.
Military and National Security: If you currently serve in the military or are a veteran, we may disclose your health information to the military upon proper request. We may also disclose your information to federal officials conducting national security and intelligence activities.
Workers' Compensation: We may disclose your information if required by workers' compensation laws and other similar laws and regulations.

YOUR PRIVACY RIGHTS

You have the right to:
Inspect and copy your health information: You may ask to review and get a copy of health information about you that the Center keeps for as long as the Center has it. If you request to review your health information, the Center will determine whether to allow you to review some or all of the health information you asked for. The Center may charge a fee for any copies that you ask for. Please make this request in writing to the Center's **Executive Director**.
Amend your health information, if you feel it is wrong o not complete: You may request that we amend the health information the Center keeps. If the Center accepts your request to amend your health information, the change will become a permanent document in your health care record. Please make this request in writing to the Center's **Executive Director.**
Request a limit to the health information we disclose: You may ask the Center not to use or disclose your health information. Your request must describe the specific limits you are requesting. The Center may deny your request. Please make this request in writing to the Center.
Request a list of disclosures we have made of your health information: You can request a list of disclosures of your health information that the Center has made. This list will not include routine disclosures of your health information for the treatment, payment, or business operations purposes described above. Please make this request in writing to the Center.
Request confidential Communications from us: We will not disclose your health information except as described in this Notice. However, you may ask us to contact you by another means or at a different address or to limit the number or type of people who have access to your health information. Please make this request in writing to the Center.
Receive a paper copy if this Notice from us: You may request a copy of this Notice at any time.

YOUR RIGHT TO COMPLAIN

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing, and all complaints will be investigated.

CHANGES TO THIS NOTICE

Changes to This Notice: We reserve the right to change this Notice at any time. We will post a copy of the current notice in the Center with the effective date in the upper right corner of the first page. You may request a copy of the current notice each time that you visit the Center for services by calling the Center and requesting that the current notice be sent to you in the mail.

PRIVACY CONTACT INFORMATION

If you have any questions about this Notice or wish to submit a request, please contact the Center at:
Name: Spring Branch Community Health Center
Address: 9325 Kempwood Drive Houston, Texas 77080
Tel: 713-462-6565
Fax: 713-462-6581