Patient Registration (All information is confidential)

Patient Name: _____ _____ _____

(Last Name) (First Name) (Middle)

Date of Birth: _____ / _____ / _____ **Social Security #:** _____-_____-_____

Sex at Birth: □ Male or □ Female **Sexual Orientation:** □ Straight □ Lesbian or Gay □ Bisexual □ Other □ Don't know □ Chose not to disclose (If left blank, will mark don't know)

Gender Identity: □ Male □ Female □ Transgender Male: Female-to-Male □Transgender Female: Male to Female □ Other □ Don't know □ Chose not to disclose (If left blank, will mark don't know)

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Race: □ Asian □ American Indian or Alaskan Native □ African American □ Native Hawaiian □ White □ Refuse to report (decline to specify) □ More than one race (Please specify): _____

Ethnicity: □Hispanic □Non-Hispanic

Mailing Address: _____

(City) _____ (State)_____(Zip) _____

County: □ Liberty □ San Jacinto □ Polk □ Montgomery □ Harris □ Other: _____

Home Phone #:_____ **Work phone#:** _____

Cell phone#: _____ **Can we leave detailed message on home/cell phone:** □Yes **or** □No

Email Address: _____*(see portal consent)*

Physical Address if different from above:_____

Emergency Contact- Name:_____ **Phone#:**_____

Relationship to patient:_____

Are you a veteran? □ Yes □ No **Are you migrant worker** □ Yes □ No; **Are you seasonal worker?** □ Yes □ No

Do you have a vision or hearing impairment? □Yes / □No If so, pleas list_____

Housing Status: ☐ Own ☐ Rent ☐ Living with other (Double up) ☐Homeless

How did you hear about us? □ Existing patient □Marketing □Billboard □Radio □Flyer/Brochure □Postcard □Doctor referral □Internet (website, Facebook, google ads, etc.) & □Other: _____

Are you employed: □Yes □No, Occupation: _____

Do you have health insurance? □Yes or □No

NOTE: *If you are NOT applying for the discount program, please note we are requesting the following information for purposes of reporting* ***ONLY:***

Please provide your household size (including yourself, spouse and any dependents under the age of 18yrs): _____

Please provide your household gross income and circle the frequency: $_____ Daily, Weekly, Bi-weekly, Monthly, Annually

Guarantor information (person responsible for payment if not patient):

Name:_____ _____ Date of birth:___/___/_____ Cell phone#: _____
(Last name) (First Name)

Insurance Information :(Please provide insurance card) ☐ **See card attached/ Given**

1) Primary insurance name: _____ Subscriber#: _____ Group#: _____

Insured Name: _____ Insured date of birth: ___/___/_____

Patient's relation to Insured: Self / Spouse / Child Other: _____

2) Secondary insurance name: _____ Subscriber#: _____ Group#: _____

Insured Name: _____ Insured date of birth: ___/___/_____

Patient's relation to Insured: Self / Spouse / Child Other: _____

For Medicare patients ONLY (please initial at each paragraph):

____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignments. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefit also apply.

____ I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be sued in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignments.

FINANCIAL POLICY:

1) I am responsible at the time of service for paying any required co-payment, co-insurance, and/or deductible. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered.

2.) I understand if I fail to pay amounts owed, the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and report the unpaid debt to a credit-reporting agency.I further understand that I will be responsible for any charges or fees incurred for such collection efforts.

3.) I recognize that by signing this form, I permit the release of medical data for myself and/or my dependents to other organizations in order to adjudicate any claims for reimbursement.

4.) All the information provided to the Health Center of Southeast Texas is truthful and accurate. I will notify the Center of any changes as they occur. Any false information will disqualify eligibility status of assistance program(s)/Sliding fee discount and result in repayment in full for all services rendered.

5.)HCSET has informed me of my full financial responsibility IF the services rendered are not covered by my insurance plan.

NO SHOW POLICY: I am aware that if my patient chart records three no shows, I will no longer be eligible to schedule an appointment. I may still be seen for acute illnesses but can only be seen on a walk-in basis.

I have read and understand the Financial Policy and above statement of the Center and agree to abide by them.

_____ _____

Signature of Patient or Authorized Representative **Date**

Authorization and Consent to Medical Care Treatment and HIPAA Acknowledgement

Patient Information:

Name: _____ **DOB:** _____ **SS#** _____

Do you have an advanced directive, a living will? If yes, list type: _____

Is this visit related to or result from an accident? □ Yes □ No

If yes, Auto / Workers' Comp / Other: _____

Primary Care Physician _____

Referring Physician (if applicable): _____

Authorization and Consent to Medical Care Treatment at Health Center of Southeast Texas

1.) I recognize that a condition exists requiring medical/surgical care, and I voluntarily consent to and authorize such medical/surgical care, treatment, and diagnostic procedures provided by the Center and its medical and professional staff, employees, and agents as deemed necessary.

2.) I am aware that medicine, surgery, and administration of medical care, are not exact sciences. I acknowledge that no guarantees have been made regarding the result of diagnostic procedures, surgical procedures, medical procedures, treatments, examinations, or care undertaken at the Center.

3.) During my medical care, if a healthcare worker is exposed to my blood, I give consent for a sample of my blood to be tested for HIV/Hepatitis antibodies, and I will be notified of the result.

For Breast and Cervical Cancer Screening (BCCS) Program Patients:

4.) I authorize my physician to enter or view data in the confidential statewide database (Med-IT) and perform case management on my case if an abnormality were to arise.

ERX Consent:

5.) I am aware that the Health Center of Southeast Texas is utilizing E-prescribing, which is computer-generated prescriptions sent by my provider directly to the pharmacy. By signing this, I agree with my provider receiving information about my prescription history from other healthcare providers/pharmacies and third-party pharmacy benefit payers about which drugs are covered.

By signing this form, I acknowledge that I have read, understood, and agree to all the information above

_____ _____

Signature of Patient or Authorized Representative **Date**

HIPAA Notices and Acknowledgments

Notice of Privacy Practices (NPP) – Acknowledgment of Healthcare Information Practices

The Health Center of Southeast Texas "Notice of Privacy Practices" provides information about how my health information may be used and disclosed. The "Bill of Rights and Responsibilities" provides information to promote the interests and wellbeing of patients and to promote better communication between the patient and the health care provider. A copy of the notices will be printed upon my request. I understand the terms of the Notice may change and that a copy of the revised Notice will be posted in the office lobby. (Initials) _____ I have been provided an opportunity to review the Notice of Privacy Practices.

Disclosure of my Medical/ Mental Health Information

(Excluding Psychotherapy notes -45 CFR § 164.508) "Psychotherapy notes do not include any information about medications, prescription, and monitoring, counseling session starts and stops times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date."

I authorize HCSET to communicate with the following individuals about my medical/mental health conditions, diagnoses, treatment, appointments (past and future), access my medical/mental health records, and financial obligations. I understand my medical/mental information may be withheld from individuals, including family members unless I list them by name below.

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship_____

Selected records as noted: **ALL** _____ **Medical Only** _____**Mental Health Only** _____

Please describe time period you allow for disclosures: _____

Other Notes: _____

I **do not** wish to permit additional family members, relatives, or close personal friends to access any information regarding my medical/mental conditions. (Initials) _____

Do you have a Medical Power of Attorney? _____ (If Yes, Please Provide Copy to Front Desk Staff)

By signing this form, I acknowledge that I have read, understand, and agree to all information above

Patient/ Authorized Rep Signature: _____Date: _____

This form will expire after three years and must be renewed. Changes must be made in writing.

Health Center of Southeast Texas

Patient Authorization for Electronic Information Sharing

Health Center of Southeast Texas participates in Healthconnect, a non-profit organization that provides a secured electronic network for Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payers of health claims such as health insurers to share your protected health information. ("PHI") A list of current Healthconnect participants is available at www.ghhconnect.org. When you join Healthconnect, your doctors can electronically search all Healthconnect participants for your PHI and use it while treating you. Healthconnect does not change who gets to see your information—it allows your information to be shared in a new way. All Healthconnect participants must protect your privacy in accordance with state and federal laws.

Health Center of Southeast Texas participates in Prisma, a medical record retrieval service which provides an automatic method of retrieving electronic records, including all participating doctors' offices, hospitals, labs, pharmacies, radiology centers. Prisma is a secure and reliable solution to obtain current/historical member chart that reside within a providers Electronic Health Records (HER) system.

By signing this Authorization, you agree that Healthconnect and Prisma and its current/future participants may use and disclose your protected health information electronically through Healthconnect/Prisma **for the limited purposes of treatment, payment, and health care operations**. You understand that Healthconnect/Prisma may connect to other health information exchanges in Texas and across the country that also must protect your privacy in accordance with state and federal laws, and you authorize Healthconnect/Prisma to share your information with those exchanges for the same limited purposes.

This authorization remains in effect unless and until you revoke it. You can revoke this authorization at any time by giving written notice to any healthcare provider who participates in Healthconnect and Prisma. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect.

☐ Greater Healthconnect ☐ Prisma

Patient Name:_____

Signature of Authorized Person:_____ Date: _____

Name (if different from Patient):_____ Relationship to Patient: _____

Initial here if you do NOT want your providers to see your records through Healthconnect. _____

Initial here if you do NOT want your providers to see your records through Prisma. _____

HEALTH CENTER OF SOUTHEAST TEXAS
PATIENT PORTAL/eMESSENGER TO HEALTH RECORDS

Please provide the following information for us to process this request. Once you agree by signing below your account will be web enabled and you will be notified via email of your username and password. (if you do not have access to a computer and /or the internet, just mark decline)

Full Name: _____ **DOB:**_____

Parent or Guardian (If patient is a minor):_____

Preferred Phone # to text or call to : ☐ **Same as listed previously** ☐ **Other:**_____

Personal Email Address for invitation to be sent to: ☐ **Same as listed previously** ☐ **Other:**_____

Note: You must choose two of the following:

If **YES** initial below:

☐ **I understand by activating the Patient Portal, I may communicate to Health Center of Southeast Texas via the portal. HCSET Providers may also send test results or other communications via the portal. I further agreed to the use of Patient Portal.**

☐ **I understand and agree to the use of eMessenger. I understand the risks, and agree to follow instructions as described to me.**

If **NO** initial below:

☐ **I decline access to Patient Portal.**

☐ **I decline access/ use of eMessenger. (if you decline you will not receive appointment reminder calls)**

Patient Acknowledgment and Agreement:

I acknowledge that I have read and fully understand The Health Center of Southeast Texas Patient Portal/eMessenger Policies and Procedures. I understand the risks associated with online communication between myself and the practice and consent to the conditions outlined above. I agree to follow the instructions herein, as well as any other instructions that The Health Center of Southeast Texas may impose to communicate online. I have been proactive about asking questions and all of my questions have been answered with clarity. I understand and concur with all information herein.

Signature: _____ **Date:** _____