REGISTRATION FORM

Welcome to CHCSCT, Inc.! We are happy you have chosen us for your care. To register, please complete this form. Several of the items below help us ensure that we are meeting the needs of the population we serve, so please be as thorough as you can. Let us know if you have any questions or if you need help in completing this form.

Today's Date:	Account No.	PCP:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	**Employer:**	**Birth date:**	**Age:**

Street address:	**Social Security no.:**

P.O. box:	**City:**	**County:**	**State:**	**Zip Code:**

Contact Information:	Would you like to communicate with us via our secure patient portal? If yes, please show us your identification and provide your email address so that we can send you an invite to the patient portal. **Email Address:** ____

Cell #:	**Home #:**	**Work #:**

Homeless Status: ☐Shelter ☐ Transitional ☐ Doubling up ☐ Street ☐ Not Homeless ☐ Unknown ☐ Other	Worker Status : ☐ Seasonal ☐ Migrant ☐ NA Public Housing Assistance : ☐ Yes ☐ No Veteran Status: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No	**Texas Resident:** ☐ Yes ☐ No	**Preferred Language Spoken:** ☐ English ☐ Spanish ☐ Other: __________ ☐ I request language translation services.

Gender identity: ☐ Man ☐ Woman ☐ Trans man / Female-to-male ☐ Trans woman/ Male-to-Female ☐ Genderqueer/ Non-binary **Sex assigned at birth:** ☐ Male ☐ Female ☐ Intersex **Sexual Orientation:** ☐ Lesbian, Gay, Homosexual ☐ Straight or Heterosexual ☐ Bisexual	**Race:** ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Black/African American ☐ Caucasian/White ☐ American Indian/Alaskan Native ☐ Native American ☐ Asian Pacific American ☐ Subcontinent Asian American ☐ More than one race ☐ Other Race	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic	**Deaf / hard of hearing:** ☐ Yes ☐ No ☐ I Request an interpreter. **Chose clinic because/referred to clinic by (Please check one box):** ☐ Dr._________ ☐ Family ☐ Friend ☐ Social Media ☐ Newspaper ☐ Website (www.CHCSCT.com) ☐ Outreach/Health Fair ☐ Other_________

PAYMENT AND INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD AT THE TIME OF REGISTRATION.
A list of insurance we accept is available and our registration staff can assist you.

Are you insured? ☐ Yes ☐ No	If you do not have insurance, you may be eligible for our sliding fee schedule or grant-supported care for your services. In order to determine your eligibility, you may be asked to provide income, family size, and other documentation.
Annual Family Income (Estimation): **$** ___________________ **Family Size:** _____________________ (includes spouse, dependent children, or other people dependent on you)	To comply with Federal law, we are required to collect information about family income and family size from all patients to determine the income by the Federal Poverty Level.

Insurance Information: Please indicate primary insurance ☐ Commercial Insurance ☐ Medicaid/CHIP ☐ Medicare ☐ Not Insured	**Company:**	**Identification Number:**
	Group Number:	**Contact Number** (on back of card):
	In whose name is your insurance? ☐ Self ☐ Other______________________	**Is the responsible party a CHCSCT patient?** ☐ Yes ☐ No
Secondary Insurance Information:	**Company:**	**Identification Number:**
	Contact Number (on back of card):	
Sex/Gender Marker with Insurance Company:	CHCSCT recognizes your gender identity. For insurance billing purposes, what sex/gender marker is on file with your insurance company? ☐ Male ☐ Female	Is your legal name on your insurance card? ☐ Yes ☐ No, it's listed as _______________________

EMERGENCY CONTACT INFORMATION

Person you would like to be contacted in case of emergency:	Relationship to patient:	Telephone no. :(Must be different from above numbers)

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT FOR SERVICES AND ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for charges and fees for my care, except any that might be covered by insurance accepted by **CHCSCT, Inc**. I also authorize **CHCSCT, Inc**. or **insurance company** to release any information required to process my claims.

- I understand that payment, including deductibles, co-insurance, co-pays and self-pay / sliding fee payments, is due at the time of service.
- For uninsured or underinsured clients: I understand that if my income, family size, or residency changes, I will bring in documentation of those changes to the registration staff. Registration staff will re-assess my eligibility on the sliding fee scale and/ or grant-supported care.

Patient/Parent/ Guardian Signature:	***Date:***
Staff Signature:	***Date***

Patient and Center Rights and Responsibilities

Welcome to the Community Health Centers Of South Central Texas (CHCSCT) Inc.,. Our goal is to provide quality health care to qualified persons in this community, regardless of their ability to pay. If we are enrolling new patients, you may be eligible to become our patient. As a patient, you have rights and responsibilities. We have rights and responsibilities also. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read this statement and ask us any questions that 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, insurance information, and Medicare or Medicaid eligibility are to be reported at each visit. We need this information to decide how much to charge you and/or bill private insurance, Medicaid, Medicare, or other benefits you may be eligible for. If your income is less than the federal poverty guidelines, you will be charged a discounted fee. It is the responsibility to report all changes after the initial visit and annually our staff will ask you for changes at the time of the visit.
- As the patient I attest that all information that I report to the clinic is true and accurate and any changes in insurance or income will be reported to the facility.
- I give the facility permission to allow all information to be audited by any administrator of programs that I am eligible for through the clinic including but not limited to: DSHS, Medicare, Medicaid, or pharmaceutical programs.
- You have a right to receive explanations of your bill. You must pay, or arrange to pay, all agreed fees for medical services or dental services, as provided by our policies. 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. Insurances will be filed, on your behalf, however, you are responsible for all applicable co-pays or deductibles and if for any reason your insurance company does not cover the services received, you will be responsible for payment in full for those services. If you are private pay at time of visit and do not qualify for any assistant programs, you are responsible for payment in full at time of visit.

Privacy

- You have a right to have your interviews, examinations and treatment in privacy. Your medical 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 Center Privacy Practices*". By signing this document you are indicating that you have received this Notice. The Notice details the various rights granted to you under 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 to, 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, and only requesting a "walk in" appointment when you are ill. We may not be able to see you unless you have an appointment. If you do understand or 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. However, we do not pay for services that you get elsewhere. **Note: The Centers are not an emergency facility.**
- If you are in pain, you have a right to receive an appropriate assessment and management, as necessary.

Center Rules

- You have a right to receive information on how to appropriately use our services. You are responsible for using our services in an appropriate manner. If you have any questions about using center services, please ask us. You are responsible for the supervision of children you bring with you to our Center. You are responsible for their safety and the protection of other clients and our property.
- You will be required to confirm you appointments by using the automated system protocol. (Appointments **NOT** confirmed within 24 hours will be automatically canceled and replaced with another patient in need of the appointment.) You must notify the Center 24 hours in advance if you are unable to attend your scheduled appointment and notify the Center of any changes in the preferred contact method. You will be required to appear on an arrival time based upon a New, Established, or Recertification status. If you are 15 minutes past your arrival time the Center will consider the appointment a "no-show". If you fail to keep **2** scheduled appointments in a **12**-month period you will be asked to come in and sign a **No Show Agreement** in order to schedule future appointments. Failure to keep **3** scheduled appointments in a **12**-month period will lead to a suspension of **6**-months. A period of 30 days will be given for urgent care services and after this period you will be responsible for finding a new healthcare provider. Once documented as having violated the no-show policy, in order to be considered for further healthcare services, patients will be required to write a letter to the Chief Executive Officer explaining the following: 1) why you missed the last appointment; 2) the reason(s) you feel you need another appointment; and 3) that you understand that another no-show will result in their suspension from the practice. Under special circumstances and at the sole discretion of the Chief Executive Officer a patient's suspension can be reconsidered.
- You have a right, to select a primary care clinician, be involved in your healthcare plan, and to seek a second opinion or specialty care within the PCHM.

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 file a complaint with the Department of State Health Services or The Joint Commission.
- We will not punish you for filing a complaint and will continue to see you as a patient.

Termination

We can decide to stop treating you as a patient. If we 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 attempt to find other health services. After notice of termination, we will only provide urgent care for a 30-day period while you find a new provider. We can decide to stop treating you immediately and without notice, if we have determined that you have created a threat to the safety of the staff and/or other clients. You also have a right to receive a copy of our termination policy. Other reasons for which we may stop seeing you include:

- Failure to obey our rules,
- Failure to follow "no-show policy"
- Intentional failure to report accurate information concerning your health,
- Intentional failure to follow the health care program, such as instructions about taking medications, personal health practices, or follow-up appointments, as recommended by your doctor,
- Creating a threat to the safety of the staff and/or other clients, and/or loud verbal or physical abuse or harassment of Center staff;
- Intentional failure to report accurately your financial status.

If we have given you notice of termination, then you have the right to appeal the decision to the Board of Directors.

I have received a copy of this document.

Consents and Acknowledgements

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information and documents. If you have any questions about any of this information or need completing this form, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information, have been given the chance to ask questions, and are giving your consent.

GENERAL CONSENT TO TREAT

I hereby authorize the Physicians, Physician Assistant, Advance Practice Nurse, Psychologist and any other Clinical Staff on staff at this Health Center, at their service locations, and consent to care encompassing routine diagnostic procedures, examinations, medical treatment and dental treatment, if applicable. This includes, but is not limited to, routine laboratory work (such as blood, urine and other studies) including HIV, taking of x-rays, heart tracing, administration of medications, procedures, examinations, psychological testing and treatment prescribed by the medical staff (physicians, mid-level providers), and dental staff if applicable, and counseling services necessary to receive family planning services as defined by federal regulation. I understand that there are no guarantees being made to me concerning the results of my treatment or the effectiveness of any birth control methods.

I further understand that a mid-level provider (Physician Assistant, Advance Practice Nurse) is not a licensed physician and may not treat or diagnose any illness, injury, or medical and/or dental condition except under the supervision and direction of a licensed physician. I further understand that I may revoke this authorization at any time and may request to be seen by a licensed physician or their designated physician replacement.

Release of Information: I authorize this Health Center to release necessary information to third party insurance carriers for the purpose of filing insurance claims related to (his/her) care. I further authorize the release of information about my treatment here to my (his/her) doctor or any designated by me.

I have read or had read to me the **Clients and Center Rights and Responsibilities** and accept that document. I certify that this form has been fully explained to me, that I have read it, or have had it read to me, that the blank spaces have been filled in ink, and that I understand its contents.

I understand that this consent form will be valid and remain in effect as long as I attend the Health 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 informed consent.

Females Only: I understand that my participation in the BCCS program will allow the Community Health Center of South Central Texas, Inc. to enter and view my information in the statewide database (MED-IT)

INTEGRATED MODEL OF CARE

The provider you are seeing integrates both physical health and behavioral health when making treatment decisions. Community Health Centers of South Central Texas works in collaboration with Bluebonnet Trails Community Services to provide primary medical, dental and behavioral health services that are integrated. I give my permission for my information to be shared between these two agencies on a need to know basis.

You are responsible for giving us accurate information about your present financial status and any changes in your financial status, insurance information, and Medicare or Medicaid eligibility are to be reported at each visit. We need this information to decide how much to charge you and/or bill private insurance, Medicaid, Medicare, or other benefits you may be eligible for. If your income is less than the federal poverty guidelines, you will be charged a discounted fee. It is the responsibility to report all changes after the initial visit and annually our staff will ask you for changes at the time of the visit.

I, ______________________________, the undersigned, hereby authorize CHCSCT, Inc. its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s).

Name: ____ Relationship to Patient:______________________________

Name: ____ Relationship to Patient:______________________________

Name: ____ Relationship to Patient:______________________________

❒ At this time I do not want my information shared with anyone

By signing my name below, I am acknowledging that I have read, and fully understand, each of the separate paragraphs set forth above.

Signature:	**Date:**
Printed Name: (If other than patient, print relationship)	**Date of Birth:**

Notice To Our Clients Regarding:

YOUR 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, and
- make sure the law and your legal rights are in effect.

HOW WE MAY USE & DISCLOSE

YOUR PERSONAL HEALTH INFORMATION

Treatment. We use information previously compiled about you to provide you 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 you 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 your 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 law 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/Privacy contact person listed below.

Amend your health information, if you feel it is wrong or 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/privacy contact person listed below.

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's Executive Director/privacy contact person listed below.

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's Executive Director/privacy contact person listed below.

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's Executive Director/privacy contact person listed below.

Receive a paper copy of 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 hand corner of the first page. You may request a copy of the current notice each time that you visit the Center for services or 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's Chief Executive Officer at:

Name:	**Henry Salas**
Address:	**228 St. George Street, Gonzales, TX, 78629**
Telephone:	**830-672-6511**
Fax:	**830-672-6430**
Email:	salash@chcsct.com

EFFECTIVE DATE

This Notice is effective as of November 19 2007. Community Health Centers of South Central Texas, Inc.

By signing ________________________________, I acknowledge having received a copy of the Patients Client Privacy