PATIENT REGISTRATION FORM

VECINO HEALTH CENTERS

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
___ American Indian or Alaska Native
___ Asian
___ Native Hawaiian/Pacific Islander
___ Black/African-American
___ White
___ More than One Race
___ Unreported/Refused to Report

ETHNICITY
___ Hispanic/Latino
___ Not Hispanic/Latino
___ Unreported/Refuse

LANGUAGE
__ English
__ Spanish
__ 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 DOB	GUARDIAN 2 DOB
ADDRESS ___ SAME AS ABOVE	ADDRESS ___ SAME AS ABOVE
CITY/STATE/ZIP	CITY/STATE/ZIP
PHONE 1 / PHONE 2	PHONE 1 / PHONE 2
RELATIONSHIP ___Mother ___Father ___Other (specify)_____	RELATIONSHIP ___Mother ___Father ___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 ___ SAME AS ABOVE	ADDRESS ___ SAME AS ABOVE
CITY/STATE/ZIP	CITY/STATE/ZIP
PHONE 1 / PHONE 2	PHONE 1 / PHONE 2
RELATIONSHIP ___Mother ___Father ___Other (specify)_____	RELATIONSHIP ___Mother ___Father ___Other (specify)_____

PATIENT OR AUTHORIZED SIGNATURE	PRINTED NAME	DATE

How did you hear about us? ___Newspaper ___TV ___Friend/Family ___Other (Specify) _____

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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 Immunodefiency 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 (ell 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 Immunodeficiencia 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: _____

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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

□ 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

□ Work Telephone
- □ O.K. to leave message with disabled information
- □ Leave message with call-back number only

□ 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

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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

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.