Central Care Integrated Health Services
Patient Registration Form

	Martin Luther King 8610 Martin Luther King, Jr BLVD Houston, Tx. 77033	Third Ward Clinic 3315 Delano Houston, Tx.77004	Hillcroft Site 14087 Main Houston, TX 77035	Acres Home Clinic 1102 Pinemont Houston, Tx. 77018	Tidwell Site 600 E. Tidwell Houston, Tx. 77022	Humble Site 14929 Old Humble Rd Humble, TX 77396

Today's Date:	☐ New Patient ☐ Established Patient			
Patient: _____ Adult _____Child	Social Security #:			
Patient's Name: Last First Initial				Date of Birth
Adult Patient/Guardian's Email	Sex: ☐ M ☐ F	Marital status: Single☐ Married☐ Divorced ☐ Separated☐ Widowed☐		
Street Address:		Home phone no: or Cell no:		
City State Zip County				Level of Education
Relation to Patient: ☐ Self ☐ Parent ☐ Legal Guardian Other _____	Name of person, if parent, legal guardian/other			
Primary Language: ☐ English ☐ Spanish ☐ Other_____	Number in Household:			
Ethnicity: ☐Caucasian ☐African American ☐Hispanic/Latino ☐Asian ☐Native American ☐Pacific Islander ☐ Other _____				
Name of Spouse (If applicable)	Are you a victim of Hurricane Katrina? ☐ Yes ☐No Are you a Veteran? ☐ Yes ☐ No			

In case of emergency contact:

Name	Relation to the Patient	Home phone no:	Work or Cell phone no:
Name	Relation to the Patient	Home phone no:	Work or Cell phone no:

INFORMATION FOR MINOR PATIENTS ONLY

If you are completing this form as a parent or guardian, list children below from oldest to youngest in the household

Name	Birth Date	Sex	Race	Social Security	Language

PLEASE READ CAREFULLY: I certify that the above information is correct to the best of my knowledge. I understand and agree that any false statements contained herein will be sufficient cause to revoke my privileges to obtain healthcare in addition to possible prosecution under the laws of perjury. I acknowledge that I have read and received the following:

(PLEASE INITIAL) _____Notice of Privacy Practices _____CCIHS'S Patient Rights and Responsibilities

New patient only: How did you find out about Central Care Integrated Health Services? ☐Self ☐Friend ☐Staff Member ☐Board Member

☐Physician Referral ☐News Media ☐Flyer ☐Webs ☐Commercial/Billboard ☐Other _____

CENTRAL CARE
INTEGRATED HEALTH SERVICES

Consent for Medical/Dental Care and Treatment, Payment Information and Payment Source Form

Patient's Name: _____**Date of Birth:** _____

I hereby consent that CCCHC PCMH shall be able to access my patient portal, so I can receive my health information (initials) _____

By initialing below, I voluntarily consent to authorize the health care providers at CCCHC to conduct examinations, diagnostic tests and procedures to evaluate my health care conditions, and to provide health care services necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. As part of the care to be given, a test may be performed for hepatitis or human immunodeficiency virus infection (HIV/AIDS). Before I undergo any procedures or tests, my provider will explain the potential benefits, risks, or side effects, including potential problems that might occur, the likelihood of success, other options including relevant risks or side effects to those alternatives, as well as information about possible results of not choosing to undergo the recommended treatment. (initials)_____

Right to Refuse Treatment Information

In giving my general consent to treatment, I understand that I may refuse any examination, test, procedure, treatment, or medication recommended or deemed medically necessary by my health care provider and that I remain responsible for decisions about my own healthcare and the consequences of those decisions. (initials)_____

A scanned copy of this consent shall be considered as valid as the original. I understand that my consent is voluntary, if I refuse to sign this consent, the healthcare providers of CCCHC may refuse to treat me. I understand these services are voluntary and I have the right to refuse these services. (initials)_____

Patient/Parent/Guardian Signature: _____Date: _____

Office Use Only : Witness: _____ **Date:** _____

Payment Information

Central Care Community Health Center is non-profit organization. Standard charges have been established for all services provided. We are not a city or county free clinic.
I understand that I will be charged a fee for services rendered to me, based upon my household income and family size.
I understand that the minimum office visit fee is $30.00.
I understand that I am fully responsible for 100% of all laboratory work that may be required by the physician.
I understand that I am required to pay all amounts in full on the same day services rendered.
Please be advised that you may/will have a remaining balance at the end of your visit.
I understand that if I have Medicaid, Medicare, or private insurance; the charges incurred from my visits will be submitted to the appropriate insurer for reimbursement. I am aware that I need to bring/present my current Medicaid/Medicare certification letter or card with me each visit. I will be responsible for any charges denied by Medicaid/Medicare or private insurance.
I understand that I am required to notify CCCHC of any changes to my financial status.
I HAVE READ AND UNDERSTAND THE PAYMENT INFORMATION

SIGNATURE: _____ DATE: _____

Payment Source

Self Pay____ Medicaid_____ Medicare _____ CHIP_____ CHIP PERINATAL_____ OTHER INSURANCE_____

In order to determine your sliding scale class, please fill out the following information and provide proof of income. If paid in cash, please provide letter from employer on company letterhead. If unemployed, please provide work history printout from The Work Source.

Name of Person Working	Relationship to Patient (self, spouse, parent, etc.)	Amount Received	How Often? Weekly/every 2 Weeks/Monthly	Number of people in household	Office Use Only
					Verified by:
					Percentage:

If you are self-employed, complete the information. I, _____ am self-employed and my income per month is approximately $_____. My occupation is: _____

☐ I certify that the above information is correct and accurate.

SIGNATURE_____ DATE_____

CENTRAL CARE
INTEGRATED HEALTH SERVICES

Initial Learning Assessment

Patient's Name: _____ Contact # _____ DOB _____

During your visit with our organization, you will be presented with information that may be new to you. To help you in providing the best care possible, please answer the following questions then return the completed form to the Front Desk. Thank you.

Highest level of education completed _____

Preferred method/style of learning

Please check all that apply:

- ☐ Reading
- ☐ Written
- ☐ Verbal
- ☐ Doing of practicing a new skill
- ☐ Participating in a small group
- ☐ Talking and asking questions
- ☐ Media, Kiosk, Videos and interactive display

Reasons that can affect learning:	Yes	No	Comments
Do you speak English in your home?			If no, what language do you speak? _____ Name of Interpreter: _____
Can you read English?			
Can you write English?			
Can you hear well?			If no, do you wear a hearing device? ☐ Yes ☐ No
Can you see well?			If no, do you wear glasses or contacts? ☐ Yes ☐ No
Do you have any cultural or religious practices/beliefs that may affect your treatment?			If yes, explain:
Preferred language			

Other Comments:

_____

Patient Authorization for Greater Houston Healthconnect

Central Care Integrated Health Services 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.

Your treatment and eligibility for benefits will not be affected in any way should you choose not to join Healthconnect.

By signing this Authorization, you agree that Healthconnect and its current and future participants may use and disclose your protected health information electronically through Healthconnect **for the limited purposes of treatment, payment and health care operations**. You understand that Healthconnect 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 to share your information with those exchanges for the same limited purposes.

Your health information that may be shared through Healthconnect includes:

- Diagnosis (disease or problem)
- Clinical summaries of treatment and copies of documents in your medical record
- Results of lab tests, x-rays and other test
- Medication (current and in the past)
- Personal information such as name, address, telephone number, gender, ethnicity and age
- Names of providers and dates of services
- Alcohol, drug abuse, mental and behavioral health treatment
- HIV/Acquired Immune Deficiency Syndrome (AIDS) test results and treatment
- Hepatitis B or C test results and treatment
- Genetic test results and treatment
- Genome information, if provided
- Family medical history, if provided

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. Your revocation will be effective within three (3) days. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect.

You understand that when your PHI is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations.

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. _____

Revised 02/11/2016