



Patient Registration Form

Patient Name (Last, First): _____		Date of Birth ____/____/____	
Mailing Address		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	
_____ Street or P.O. Box		Marital Status	
_____ City State Zip Code		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Physical Address <input type="checkbox"/> Same as Mailing		Gender Identity	
_____ Street		<input type="checkbox"/> Female <input type="checkbox"/> Male Other _____	
City State Zip Code		<input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male	
Phone Numbers		Sexual Orientation	
Cell _____		<input type="checkbox"/> Straight <input type="checkbox"/> Gay <input type="checkbox"/> Bisexual	
Home _____		Other _____	
Work _____		Decline to specify _____	
Email Address		Race (Check all that apply)	
_____		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian	
Preferred Language		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian	
<input type="checkbox"/> English <input type="checkbox"/> Español <input type="checkbox"/> Tiếng Việt Other _____		<input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Decline to specify	
Responsible Party (For Minor Patient)		Ethnicity	
Name _____		<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Decline to specify	
Phone _____ Relation _____		<input type="checkbox"/> Hispanic or Latino	
		Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Emergency Contact	
		Name _____	
		Phone _____	
Insurance Information			
Primary Insurance			
ID# _____		Group #: _____	
Policy Holder:			
Policy Holder DOB: ____/____/____		Relation: _____	
Secondary Insurance:			
ID# _____		Group #: _____	
Policy Holder:			
Policy Holder DOB: ____/____/____		Relation _____	



Patient Health History

Patient Name: _____ Date of Birth: _____

Please mark if you have, or have ever had, any of the following conditions or symptoms, or mark NONE:

MEDICAL HISTORY					None
___ Acne / Skin Problems	___ Bladder Infection	___ Heart Disease	___ Thyroid Problems	___ Stomach	
___ Asthma / Lung Disease	___ Heart Attack	___ High Blood Pressure	___ Vision Problems	___ Scoliosis / Back Problems	
___ Sleep Problems/ Apnea	___ Headaches / Migraines	___ Stroke	___ Hearing Problems	___ Pregnancy Problems	
___ Liver Disease	___ Seizures / Epilepsy	___ Sexually Transmitted Disease	___ Sickle Cell Disease	___ Blood Transfusions	
___ Hepatitis	___ Cancer	___ Diabetes	___ Anemia	___ Tuberculosis	

Please list other health conditions or concerns:

FAMILY HISTORY

Mark if anyone in your family currently has, or has ever had any of the following:

	Cancer	Diabetes	High Blood pressure	Thyroid problems	Heart Attack	Stroke	Drug/Alcohol Abuse	Learning Problems	Mental Illness	Other: (List)
Mother										
Father										
Sibling(s)										
Other _____										
Other _____										

SOCIAL & BEHAVIORAL HISTORY

SOCIAL & BEHAVIORAL HISTORY					None
___ ADHD	___ Low Self-Esteem	___ Depression / Anxiety	___ Drug/Alcohol Abuse	___ Eating Disorder	
___ Autism	___ Attempted Suicide	___ Housing/ Financial Problems	___ Family Stressors	___ Physical / Emotional Abuse	
___ OCD	___ Mental Illness	___ Learning Problems			
___ Drink Alcohol: Frequency _____			___ Smoke/Tobacco: Type _____ Frequency _____		

SURGERIES / HOSPITALIZATIONS

Age	Reason	Hospital

CURRENT MEDICATIONS

Prescription / Vitamin / Supplement / Over-the-Counter Medication	Strength / Dose	Frequency Taken

ALLERGIES/DRUG INTOLERANCES

ALLERGIES/DRUG INTOLERANCES	Reaction	None

NAME OF PREVIOUS OR CURRENT Primary Care Provider (PCP)

NAME OF PREVIOUS OR CURRENT Primary Care Provider (PCP)	Phone #

PREFERRED PHARMACY

PREFERRED PHARMACY	Phone #



Patient Information Documents and Consents

My signature below acknowledges I have been provided with a Patient Information Package, which includes:

Consent to Treatment, Testing, and Procedures

I consent to all tests, treatments and procedures ordered by Coastal Gateway Health Center (CGHC) providers including, without limitation, testing for communicable or blood-borne diseases such as sexually transmitted diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis. As part of my testing and treatment, I may receive disease-specific prevention, education, and risk-reduction services. I understand that CGHC is required by state law to report information to the Chambers County Health Department and/or the Department of Health and Human Services (DSHS) for persons who test positive for certain diseases (known as 'reportable diseases') including, but not limited to, tuberculosis, HIV/AIDS, and syphilis. If I test positive for a reportable disease, I understand that I will be contacted by a state-authorized Disease Intervention Specialist to promote successful treatment and notification of any sex partners, if applicable, who may be at risk for the disease. I also understand that if a CGHC healthcare worker is accidentally exposed to my blood or body fluids, (for example by a needlestick or a sharp instrument), CGHC can draw and/or use blood drawn from me for testing purposes.

Physician Assistant/Nurse Practitioner Consent

CGHC has on staff, Physician Assistants and/or Nurse Practitioners, to deliver medical care. A Physician Assistant and/or Nurse Practitioner is a graduate of a certified training program and is licensed by a State Board. Under the supervision of a physician, a Physician Assistant and/or Nurse Practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. 'Supervision' does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. I have read the above, and by signing below hereby consent, to the services of a Physician Assistant and/or Nurse Practitioner for my healthcare needs. I understand that at any time I can refuse to see the Physician Assistant and/or Nurse Practitioner and request to see a physician.

Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP) for CGHC. I authorize the use and disclosure of my protected health information to carry out treatment, conduct payment activities, and for general healthcare operations.

Financial Responsibility

I understand that if I qualify for services through a grant funded program (i.e. Sliding Fee Discount Program) these resources are payers of last resort. As payers of last resort, grant-funded programs may not continue my eligibility if I currently, or in the future, have Medicare, Medicaid and/or third-party insurance coverage. Therefore, I agree to immediately report any changes in my financial status and/or insurance coverage to the Eligibility Clerk. If I fail to appropriately report changes in my financial status



and/or insurance coverage, and if those changes result in my ineligibility for services under a grant funded program, I understand that I am fully responsible for the cost of services delivered by CGHC.

Insurance Assignment

By signing below, if I am eligible for Medicaid, Medicare and/or third party insurance coverage while a client of CGHC, I authorize CGHC to furnish to Medicaid, Medicare and/or third party insurance coverage all of the necessary information, including my HIV status, to process my claim. I also hereby assign to CGHC all payments received from Medicaid, Medicare and/or a third party insurer for services and treatments provided to me by CGHC. I understand that I may be responsible for paying any required co-payments prior to being seen by a healthcare provider. I also understand that I am responsible for the cost of services and treatments delivered to me that are not covered by my insurance.

e-Prescribing

e-Prescriptions, e-Rx or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. CGHC participates in e-prescribing because we care about your health and well-being and e-prescribing has multiple benefits. By consenting, CGHC can also access a history of my current and past prescriptions. This critical information assists CGHC in confirming the safety of my prescriptions and minimizing dangerous interactions with my other medications.

Communications

I understand that my email address and other contact information that I have provided will be used by CGHC, or other authorized third parties acting on behalf of CGHC, for various purposes including, but not limited to, patient surveys, marketing messages, appointment reminders, prescription medication refill reminders, and registration for CGHC's through the patient portal through of the Electronic Medical Record (EMR). CGHC's secure patient portal allows patients to communicate with their healthcare providers and access some information in their medical records, such as medication lists, certain laboratory results, and immunization records, however, these features may change from time-to-time. I understand that my email address will be used by CGHC to create a secure portal account for me, but that I will be required to establish my login information in order to access the portal. The patient portal for the health center is known as Healow. I understand that CGHC, or authorized third parties, will not share my mobile number with external parties, that text (or SMS) messaging frequency may vary and that message and data rates may apply.

Greater Houston Healthconnect

CGHC participates in the Greater Houston Healthconnect (GHHHC), a non-profit organization that provides a secure electronic network for GHHHC participants. A list of current GHHHC participants is available at www.ghhconnect.org. GHHHC's participation with others in GHHHC, such as labs, pharmacies, radiology centers, doctors' offices, hospitals, and health insurers, permits CGHC to access, and utilize in providing care to you, any available electronic health information related to you. All GHHHC participants must protect your privacy in accordance with state and federal laws. Your treatment and eligibility for benefits will not be affected. By my signature below, I agree that GHHHC and its current and future participants, including CGHC, may use and disclose my protected health information electronically for the limited purposes of



treatment, payment and health care operations. I understand that GHHC may connect to other health information exchanges in Texas and across the country that also must protect my protected health information in accordance with state and federal laws, and I authorize GHHC to share my information with those exchanges for the same limited purposes of treatment, payment and health care operations. This authorization remains in effect unless and until I revoke it. I understand that I can revoke this authorization at any time by giving written notice to any healthcare provider who participates in GHHC and my revocation will be effective within three (3) days. I also understand that revoking this authorization does not affect information previously shared when my authorization was in effect.

Photographs

I understand and authorize CGHC to take and/or use photographs or electronic images for the purpose of identity verification and/or my medical care. All photographic images will be taken using a CGHC approved devices. CGHC provider's and/or staff members will not use personal devices/cell phones to capture these images.

Important Information You Need to Know about Telehealth/Telemedicine

Limitations of Telemedicine/Telehealth

As a CGHC patient receiving services via telemedicine/telehealth, your provider is required to provide notice (an explanation) regarding telemedicine/telehealth services, including the risks and benefits of being treated via telemedicine/telehealth, how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure.

Necessity of In-Person Evaluation

As a CGHC patient receiving services via telemedicine/telehealth, your provider is required to inform you before the conclusion of the encounter, if they are unable to provide all pertinent clinical information that a health care provider exercising ordinary skill and care would deem reasonably necessary for the practice of medicine or health services at an acceptable level of safety and quality in the context of that particular medical encounter. If that occurs, your provider is required to advise you to obtain additional medical evaluation reasonably able to meet your needs.

Rights and Responsibilities, Recording Telemedicine Appointments

I understand that by agreeing to participate in CGHC's telemedicine/telehealth services, I will not audio and/or audio/video record CGHC provider's or staff members without their express permission obtained in advance of any recording. A violation of this recording limitation may result in CGHC requesting that I destroy the recording, including any postings of the materials that have been shared and may also result in CGHC discontinuing telemedicine/telehealth services to me.

Complaints to the Board

As a CGHC patient receiving services, if you wish to file a grievance or complaint with the Texas Board of Medicine or CGHC Compliance Officer, please contact CGHC by email at admin@coastalgatewayhc.org,



or via phone at 409.296.4444, or via mail at P.O. Box 2264, Winnie, Texas 77665. You will not be penalized for filing a complaint.

Terms of Consent

I understand my consent is necessary for CGHC to offer services to me and that some items may not apply to my current situation. I also understand that, in order to provide comprehensive care during this and future visits, and to evaluate my eligibility for programs, my signature below indicating my agreement to this document in its entirety, is required. By signing this form, I acknowledge and agree to the terms, information and obligations contained in this document. I am giving this consent of my own free will. I have had the opportunity to read and ask any questions about the information in this packet, specifically including, but not limited to, the financial obligations provisions and assignment of benefit provisions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction in a language I understand. I sign this document freely and agree to abide by its terms. I understand that this document remains in effect until I revoke my consent, at any time, in writing. I also understand that revoking this authorization does not affect any actions previously taken based on this consent.

By signing this form, I attest that all the statements I have made, including my answers to all questions, are true and correct. to the best of my knowledge and belief. I agree to give the CGHC eligibility staff any information necessary to confirm statements about my eligibility. I understand that giving false information could result in eligibility disqualification and a possible repayment obligation. I also agree to inform the eligibility staff should my income or number of people in my family change.

Signature of Patient and/or Parent/Guardian

Date

Signature of Person Who Assisted in Completing Form

Date