Patient Registration Form

COASTAL GATEWAY HEALTH CENTER

Patient Name (Last, First):

Date of Birth _____/_____/_____

Mailing Address

_____
Street or P.O. Box

_____
City **State** **Zip Code**

Physical Address _____ **Same as Mailing**

_____
Street

_____
City **State** **Zip Code**

Phone Numbers

Cell _____

Home _____

Work _____

Email Address

_____

Preferred Language

___ English ____ Español ____ Tiếng Việt Other_____

Sex _____Female _____Male

Marital Status

_____Single _____Married
_____Divorced _____Widowed

Gender Identity

___Female___ Male Other_____
___ Transgender Female
___Transgender Male

Sexual Orientation

___Straight ___Gay ___Bisexual
Other_____
Decline to specify_____

Race (Check all that apply)

___White ___ African American/Black ___Asian
___American Indian or Alaska Native ___Native Hawaiian
___Other Pacific Islander ___Decline to specify

Ethnicity

___Not Hispanic/Latino ___Decline to specify
___Hispanic or Latino

Veteran	**Disability**
___Yes	___Yes
____No	___No

Responsible Party (For Minor Patient)

Name

Phone_____ **Relation**_____

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 ___None

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 ___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 ___None

Age	Reason	Hospital

CURRENT MEDICATIONS ___None

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

ALLERGIES/DRUG INTOLERANCES Reaction ___None

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

PREFERRED PHARMACY Phone

Consent for Use and Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the CGHC Business Office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment and payment of healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your consent.

Name: _____ Medical Record #: _____

Address: _____ Phone: _____

_____ Email: _____

I also authorize the following person(s) to receive my personal health information, in my absence. I understand that this form will continue on file with the Registration Department, and should I request to remove the listed individual(s) from my authorization list, I will submit a written request to remove them from the authorized list.

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient:

Signature: _____ Relationship: _____

Witness: _____

Department: _____

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 (GHHC), a non-profit organization that provides a secure electronic network for GHHC participants. A list of current GHHC participants is available at www.ghhconnect.org. GHHC's participation with others in GHHC, 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 GHHC 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 GHHC 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**