HealthPOINT

A dba of Brazos Valley Community Action Agency, Inc.

Patient Registration Form

Patient and HealthPoint Rights and Responsibilities

We do not discriminate against any person on the basis of race, color, national origin, sex, age, religion, or disability in our programs and services.

PATIENT INFORMATION

Please provide your photo ID to the front desk team.

Last Name

First Name

Date of Birth

SSN

Primary Language

Sex Assigned at Birth: ☐ Male ☐ Female

Transgender: ☐ Yes ☐ No

Mailing Address

Physical Address

☐ Homeless

Home Phone

Work Phone

Ext.

Cell Phone

E-mail Address

We may contact you through the methods above for appointment and general health reminders unless you indicate a method you prefer we not use.

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown

Race (check all that apply):

☐ White (incl. Hispanic/Latino) ☐ Black or African American ☐ American Indian / Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

INSURANCE OR PAYMENT SOURCE

Please provide your insurance card(s) to the front desk team.

☐ Medicaid ☐ CHIP ☐ Medicare ☐ Private Pay (self-pay)

☐ Commercial Insurance — Name:

☐ Medicare with Supplement Insurance — Name:

☐ Other:

EMPLOYMENT / MILITARY STATUS

Select all that apply.

☐ Full-time ☐ Part-time ☐ Self-Employed ☐ Not Employed ☐ Retired ☐ Veteran ☐ Active-Duty Military

In the past 12 months, was your main job seasonal or migratory farm work?

☐ Yes ☐ No

RESPONSIBLE PARTY

☐ Self (patient listed above) ☐ Person responsible for payment (please complete the details below)

Last Name

First Name

Date of Birth

Relationship to Patient

Address

Best Contact Telephone: ☐ Home ☐ Cell ☐ Work

Best Contact Telephone Number

EMERGENCY CONTACT

Last Name

First Name

Home Phone

Work Phone

Ext.

Cell Phone

Relationship to Patient

PREFERRED PHARMACY & ADVANCE DIRECTIVE

Pharmacy Name

Pharmacy Address

Do you have an Advance Directive on file?

☐ Yes ☐ No

If yes, please provide us a copy. If we do not have a copy on file, we will follow the medical standard of care. Learn more at texaslawhelp.org/article/advance-directives

Initial

I acknowledge my responsibility to pay for services rendered and understand that I will be responsible for any fees that are not paid by my insurance or covered by HealthPoint programs.

Signature of Patient / Responsible Party

Date

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General Consent for Care and Treatment

The information in this consent form outlines your rights, as our patient, to be informed about your condition and the recommended medical or diagnostic procedures your provider may use throughout the course of your relationship with HealthPoint.

On behalf of myself or the patient named below, I acknowledge and consent to the statements made in this form.

CONSENT TO HEALTH CARE SERVICES

I am requesting that health care services be provided to me, or the patient named below, at HealthPoint. I voluntarily consent to all medical treatment and health care-related services that the providers at HealthPoint consider to be necessary for me or the patient named below. These services may include diagnostic, therapeutic, imaging, and laboratory services, including sensitive diagnosis testing, which may include HIV testing. I am aware that the practice of medicine is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

ADDITIONAL CONSENT

I understand that HealthPoint, in addition to the above general consent, may provide certain services that require special consent forms that must be read and signed for treatment and services such as telehealth services with a health provider who is at a remote site; treatment and diagnostic testing of a minor; medication or immunizations administration; or behavioral health services.

TO THE PATIENT

You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

ACKNOWLEDGMENT OF RECEIPT OF HEALTHPOINT WELCOME PACKET

We understand that information about you and your health is confidential, and we are committed to protecting your health information. As a patient you are required to review and sign this consent form prior to receiving care. Your authorization allows HealthPoint staff to use your health information for treatment, payment, and our health care operations. Additional information regarding protection of your medical information can be found in the Notice of Privacy Practices that is included in this packet or may be found on our HealthPoint website.

NOTICE OF PRIVACY PRACTICES

☐ I understand that I have the right to review and request a copy of HealthPoint's Notice of Privacy Practices and my patient rights and responsibilities at any time.

CONSENT FOR TREATMENT, REFUSAL OF TREATMENT, AND DISCLOSURE OF HEALTH INFORMATION

☐ I understand that I have the right to refuse treatment at any time. I can do so by signing a Refusal of Treatment form. I also give consent to use and disclose health information necessary for treatment and payment and other healthcare operations.

By initialing above, I indicate that (1) this consent will continue in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this health center or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. I have the right, at any time, to discontinue services.

For Minor Patients: If the patient is under 18 years of age, consent must generally be provided by a parent, legal guardian, or other individual authorized by law to consent to treatment on the minor's behalf. In circumstances where a minor may legally consent to their own care under applicable state or federal law, the minor's signature and initials shall constitute valid consent for the services authorized by law.

I understand that if additional testing, invasive or interventional procedures, or other services requiring specific consent are recommended, I will be asked to read and sign additional consent forms prior to those services being provided.

TEACHING FACILITIES

I understand that many HealthPoint locations are teaching facilities for individuals in professional training programs, including but not limited to medicine and nursing. These individuals may participate with or assist my provider in the performance of medical or diagnostic procedures/treatment. I have the right to be informed when a healthcare student will be assisting, and I have the right to request the student not assist in my examination and/or treatment.

USES AND DISCLOSURES OF HEALTH INFORMATION

I acknowledge that my medical records may be kept or reviewed at locations within HealthPoint other than the health center where I am receiving care. I understand that medical or other information acquired in the past by a HealthPoint provider and any information relating to the care provided at a HealthPoint health center may be used or disclosed, from time to time, to any other provider(s) for treatment, payment, or healthcare operations purposes.

I acknowledge that minimally necessary information regarding my treatment at HealthPoint may be released by HealthPoint in order to comply with Federal and State law, including the Health Insurance Portability and Accountability Act of 1996 and the Texas Medical Records Privacy Act. This authorization does not include permission to release outpatient Psychotherapy Notes.
Release of Psychotherapy Notes requires a separate authorization.

ELECTRONIC PRESCRIPTIONS

I acknowledge HealthPoint may transmit my prescriptions electronically ("e-prescribing") to the pharmacy designated as my primary pharmacy provider. HealthPoint may request and obtain the history of all my past prescriptions from other health care providers and/or third-party pharmacy benefit payors. I understand that such information will become part of my HealthPoint electronic health record.

Unless otherwise prohibited, HealthPoint's pharmacy, in accordance with the Texas Prescription Monitoring Program (PMP), as a licensed pharmacy, is required to report all dispensed controlled substances records to the PMP. The reporting requirement applies to all controlled substances. Pharmacists and the prescribing provider are required to check the patient's PMP history before dispensing or prescribing specific controlled substances.

CONSENT FOR ELECTRONIC COMMUNICATION

☐ I, the patient, responsible party, or authorized guardian, authorize HealthPoint and its clinical staff to communicate with me via my Patient Portal account by providing visit summaries and lab results electronically, as well as sending and receiving secure messages. I understand that web-based communication is offered as an option, and I may choose not to register with HealthPoint's Patient Portal.

CONSENT FOR COMMUNICATION

☐ I, the patient, responsible party, or authorized guardian, authorize HealthPoint and its clinical staff and any affiliate or agent of HealthPoint to contact me or others identified below as a member of my health support group utilizing my personal email address; by cell phones via text messages and/or telephone calls and/or home phones, using pre-recorded messages, artificial voice messages, automatic telephone dialing systems, or other computer-assisted technology. I understand that standard message and data rates may apply and that charges may be assessed by my wireless or telephone service provider. I understand that my consent to receive calls or text messages is voluntary and is not a condition of receiving medical care or services from HealthPoint.

LANGUAGE ASSISTANCE AND ACCESSIBILITY

HealthPoint's health centers offer language assistance services free of charge and strive to make reasonable accommodations for patients with disabilities.

IDENTIFICATION VERIFICATION

For patient safety, privacy, and accurate billing purposes, I understand that HealthPoint may request and verify photo identification to confirm my identity or that of the patient(s) for whom I am the parent, legal guardian, or authorized representative. This helps ensure accurate medical records, prevent insurance fraud, and protect patient confidentiality. If I have questions about this policy or am unable to provide photo identification, I understand that I may contact HealthPoint staff for assistance and additional information.

RECORDING AND PHOTOGRAPHY TREATMENT – TEACHING PROVIDERS, RESIDENTS, OTHER HEALTHCARE PROFESSIONALS

☐ I hereby consent and grant to HealthPoint the right and authority to photograph and/or record me, my image, and voice for the purpose of identification and documentation of clinical care. I also understand that such images may be used for teaching purposes. I understand that I have the right to request cessation of recording or filming at any time.

USE OF ARTIFICIAL INTELLIGENCE IN DIAGNOSTIC OR TREATMENT-RELATED SERVICES

I acknowledge the provider may use artificial intelligence (AI) in diagnostic or treatment-related services, which may occur in connection with my diagnosis and treatment. Your provider will review all records created with artificial intelligence to be consistent with Texas Medical Board medical records standards. I understand that I have the right to request that any AI-assisted recording, monitoring, filming, or data collection be stopped at any time.

HEALTH INFORMATION EXCHANGE (HIE)

A Health Information Exchange (HIE) allows your care team at HealthPoint and other providers to securely share your medical records electronically — helping ensure everyone involved in your care has the information they need.

Please choose one:

☐ **OPT IN**
Share my records through the HIE.

☐ **OPT OUT**
Do not share my records through the HIE.

Information shared through the HIE may be passed on by other providers and may no longer be protected by federal or state privacy laws. You may change your choice at any time by asking any HealthPoint staff member.

ORGANIZED HEALTH CARE ARRANGEMENTS

We may participate in joint arrangements with other health care providers or health care entities whereby we may use or disclose your health information, as permitted by law, to participate in joint activities involving treatment, review of health care decisions, quality assessment or improvement activities, or payment activities.

MARKETING PROMOTIONS

☐ I consent to receive communications from HealthPoint's Marketing Team to my cell or home phone number I provided via a text message and/or a phone call.

FEDERALLY DEEMED FACILITY

I understand that HealthPoint is a federally deemed facility under the Federal Tort Claims Act, meaning that HealthPoint is considered a part of the federal government for the purposes of civil liability.

DURATION OF CONSENT

This consent will remain in effect until I withdraw my consent. If HealthPoint changes the nature of its services, or it has been at least two years since my last appointment, I will be asked to complete another general consent for treatment.

PATIENT / REPRESENTATIVE SIGNATURE

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I have been given the opportunity to ask questions regarding this consent, and I certify that this form has been fully explained to me and that I understand its contents.

Signature of patient or personal representative

Date

Printed name of patient or personal representative

Relationship to patient

For HealthPoint use only: Fillable form based on the General Consent for Care and Treatment. Review internally before use.

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Third-Party Disclosure of Information

Consent to Verbally Share Health Information

Purpose: This form allows you to give HealthPoint permission to verbally share your health information with another person or organization. You choose what is shared, and what is not. Please complete all sections that apply to you and sign at the bottom.

How long is this valid? This authorization is in effect until the patient revokes or withdraws the consent in writing, or a specific end date you choose (optional). You can withdraw your permission at any time by completing the last section of this form.

SECTION 1 – PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Date of Birth

SECTION 2 – WHO CAN MY INFORMATION BE DISCLOSED TO?

Complete the fields below for the person or organization (employer, school, etc.) with whom you authorize us to discuss your health information verbally:

Name of Person/Organization

City | **State** | **Zip Code**

Phone Number | **Fax Number**

Name of Person/Organization

City | **State** | **Zip Code**

Phone Number | **Fax Number**

SECTION 3 – WHAT INFORMATION IS INCLUDED?

By signing this form, ALL of the information types listed below are included in this disclosure. If there is anything you do NOT want shared, please check the box next to it.

☐ **Check here if you want to EXCLUDE specific items, then check each item below you do NOT want discussed:**

- ☐ History / Physical Exam
- ☐ Consult Notes
- ☐ Past/Present Medications
- ☐ Lab Results
- ☐ Radiology Reports & Images
- ☐ Billing Information
- ☐ Diagnostic Test Reports
- ☐ Allergies
- ☐ ALL Records

Other (specify):

SECTION 4 – SENSITIVE INFORMATION (INITIALS REQUIRED)

By law, certain types of health information require your initials before they can be disclosed, even if you signed above. Initial only the lines for information that may be disclosed. Leave blank to exclude.

- _____ Mental Health Records
- _____ Genetic Information (including test results)
- _____ Substance Use Disorder Records
- _____ HIV/AIDS Test Results & Treatment

SECTION 5 – SIGNATURE

I have read this form and agree to the verbal communication of my health information as described above. I understand that HealthPoint is not responsible for how the recipient uses this information once it has been released.

Today's Date

Signature of Patient or Legally Authorized Representative

Printed Name of Legally Authorized Representative (if applicable)

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Other:

REVOCATION

You may cancel this authorization at any time by signing and dating below and returning this form to HealthPoint.

Revocation Signature

Date

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PATIENT AND HEALTHPOINT RIGHTS AND RESPONSIBILITIES

Patient Name:

Date of Birth:

Welcome to HealthPoint

Our goal is to provide the highest quality health care that is both affordable and accessible to everyone. As a HealthPoint patient, you have certain rights and responsibilities, and HealthPoint also has rights and responsibilities. We want you to understand these rights and responsibilities so that we can work together to provide you with the best possible care.

Please read this statement carefully, sign where indicated, and feel free to ask any questions you may have.

Your Rights as a HealthPoint Patient

Nondiscrimination

You have the right to be treated with dignity and respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental disability, age, veteran status, or other characteristics protected by federal, state, and local laws and regulations.

Payment

All patients of federally qualified health centers are expected to contribute financially toward the cost of their healthcare services. HealthPoint offers eligibility screening for various state and federal assistance programs that may help cover healthcare costs. Patients whose household income is at or below 200% of the Federal Poverty Guidelines and who meet the eligibility requirements will be informed of their applicable nominal office visit fee at the time eligibility is determined.

Privacy

You have the right to have your interviews, examinations, and treatment conducted in a private and confidential manner. Your medical records are also protected and kept confidential.

You have the right to receive a complete explanation of your privacy rights as a HealthPoint patient through our Notice of Patient Privacy Rights. This document provides a comprehensive overview of how your medical information may be used and disclosed. By signing the Patient and HealthPoint Rights and Responsibilities, you confirm that you have received information regarding your privacy rights.

Health Care

You have the right to help make decisions about your care and treatment.

You have the right to know about your health condition and treatment plan. This includes: What treatment you need; How the treatment may help you; Possible risks or side effects; What could happen if you choose not to get treatment; Other treatment choices, if available; What results you can expect.

After you receive this information and agree to treatment, you are giving informed consent.

You have the right to receive information in the language you speak and in words you can understand.

You have the right to receive information about Advance Directives, which are legal documents that explain your healthcare wishes. If you do not want this information, or if it is not appropriate to give directly to you, we may provide it to your legal representative.

If you are an adult, you have the right to refuse treatment as allowed by law. If you choose not to receive treatment, we will explain the possible risk and what could happen because of that decision.

You have the right to receive healthcare services that meet your needs and that HealthPoint can provide. HealthPoint is not an emergency care center. If you need services we cannot provide, we will refer you to another provider or facility. HealthPoint is not responsible for paying for services you receive from another healthcare provider.

If you are in pain, you have the right to have your pain assessed and treated as needed.

HealthPoint Rules

You have the right to learn how to use HealthPoint's services. If you have any questions, please ask us.

You have the right to receive a copy of HealthPoint's "Patient Communication Regarding Noncompliance and Termination Policy" and are expected to follow it.

You have the right to receive a copy of HealthPoint's "No Show Policy," and are expected to follow it.

If HealthPoint decides it can no longer provide your care, you will receive written notice explaining why. You will have thirty (30) days to find another primary care provider.

If you receive a termination, you have the right to appeal the decision to the Chief Medical Officer.

Complaints

You have the right to tell us how we can improve our services. HealthPoint staff can help you submit a suggestion or file a complaint. If you are not satisfied with how your concern is handled, you may contact HealthPoint's Administration.

We encourage you to share your concerns with us first, but you always have the right to file a complaint with the Texas Department of State Health Services or Department of Health and Human Services.

Your Responsibilities as HealthPoint Patients

Payment

You are responsible for giving HealthPoint correct and up-to-date information about your insurance and financial situation. This information helps us determine what you may owe and whether you qualify for programs that can help pay for your care. You are responsible for paying or making arrangements to pay for your medical and dental services. If you cannot pay right away, please talk with our staff so we can discuss payment options.

Privacy

You are responsible for telling us who may or may not have access to your medical information. HealthPoint staff can provide forms that allow you to give or deny permission for others to access your records.

If you are a parent or legal guardian, please let staff know if someone other than yourself or your child's legal guardian may be bringing the child to receive services.

Health Care

You are responsible for giving us complete and accurate information about your health so we can provide the best care possible.

If you choose not to follow a recommended treatment plan, you are responsible for understanding the possible risks and outcomes. You may be asked to sign a form showing that you declined treatment.

You are responsible for using HealthPoint services appropriately. This includes following staff instructions and keeping your scheduled appointments.

HealthPoint professionals may not be able to see you unless you have an appointment.

HealthPoint Rules

You are responsible for using HealthPoint's services in a respectful and appropriate manner. Please treat HealthPoint staff, providers, patients, and visitors with respect at all times. Threatening, abusive, violent, fraudulent, intentionally offensive, or unlawful behavior will not be tolerated. HealthPoint may immediately end its relationship with you without written notice if your behavior threatens the safety of staff, patients, or visitors. HealthPoint may also stop providing care in accordance with its policies if your behavior repeatedly interferes with your care or your relationship with your healthcare provider.

You are responsible for supervising any children that you bring with you to HealthPoint.

You are responsible for your children's safety, and helping protect other patients, staff, and HealthPoint property.

You are responsible for keeping your scheduled appointments. Missed appointments can delay care for other patients.

HealthPoint has the right to stop providing your care if you violate HealthPoint's rules or policies.

HealthPoint's Responsibilities as Your Provider

General

HealthPoint is responsible for providing quality healthcare in a safe environment that protects your rights as a patient.

Complaints

HealthPoint has the responsibility to ensure that no HealthPoint representative will punish, treat you unfairly, or stop your care because you file a complaint. You have the right to share concerns, ask questions, or file a complaint without fear of retaliation. HealthPoint will continue to provide appropriate services while your concern is being reviewed.

You are responsible for adhering to HealthPoint's No Show Policy. If you miss an appointment or do not give enough notice when canceling, you may lose the ability to schedule future appointments.

HealthPoint's Rights as Your Provider

Privacy

In some situations, HealthPoint may be required by law to share your medical information with state or federal agencies for reporting or investigations.

HealthPoint may also be required to share your medical records if ordered by a court.

Patient's Name or Name of Responsible Party (if applicable)

Signature of Responsible Party

Relationship to Patient (if applicable)

Today's Date

For HealthPoint use only: Fillable form based on Patient and HealthPoint Rights and Responsibilities. Please review internally before use.