Spring Branch
COMMUNITY HEALTH CENTER
Healthy Families. Healthy Community.

Visit us at any of our 8 Locations

Hillendahl Clinic
1615 Hillendahl Blvd., Suite 100
Houston, TX 77055
(713) 462-6565

Hours
Monday-Wednesday: 7am-7pm
Thursday-Friday: 8am-5pm

WholeLife Clinic
1905 Jacquelyn Drive, Suite 101
Houston, TX 77055
(713) 231-5767
Parking access: 1838 Johanna Dr,
Houston TX 77055

Hours
Monday-Friday: 8am-5pm

Pitner Clinic
8575 Pitner Road
Houston, TX 77080
(713) 462-6545

Hours
Monday-Friday: 8am-5pm
Saturday:8am-12pm

West Houston Clinic
19333 Clay Road
Katy, TX 77449
(713) 462-6555

Hours
Monday-Friday: 8am-5pm

Katy Clinic
5502 1st Street
Katy, TX 77493
(713) 231-5757

Hours
Monday-Friday: 8am-5pm

Cy-Fair Clinic
7777 Westgreen Blvd.
Cypress, TX 77433
(713) 387-7180

Hours
Monday-Friday: 8am-5pm

NAM Clinic
15555 Kuykendahl Road, Suite 319
Houston, TX 77090
(281) 885-4630

Hours
Monday-Friday: 8am-5pm

Contact us at:

www.sbchc.net

Please review us on:

Memorial Clinic
902 Frostwood Drive, Suite 108
Houston, TX 77024
(713) 827-4744

Hours
Monday-Friday: 8am-5pm

Medical Fax: (346) 299-5173 // Behavioral Health Fax: (346) 330-2518 // Dental Fax: (346) 299-5193
Housing Fax: (346) 299-1785 // Admin Fax: (832) 831-5369

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SPRING BRANCH COMMUNITY HEALTH CENTER REGISTRATION INFORMATION

Financial Assistance Program

The Financial Assistance Program is a special program that may assist those who have difficulty paying for care. If you are not eligible for insurance coverage and have limited income, you can apply for a sliding fee discount. In order to qualify, please bring the following:

❑ PROOF OF IDENTITY

You will need proof of identity for **you and your family members**. Valid documents include: driver's license, state identification card, student ID with picture, passport with picture, U.S. immigration documents with picture, ID issued by foreign consulates, U.S. naturalization citizenship, birth certificate, voter's registration card.

❑ PROOF OF RESIDENCY

You will need one proof of residency, which can include the following documents:

a. Dated within the past 60 days: utility bill, mortgage statement, rental verification form, commercial mail addressed to you or your spouse, printout from Texas Workforce Commission, domicile verification form completed by a reliable person not living with you.

b. Dated within the past year: lease agreement, Department of Motor Vehicle documents, property tax statement, automobile insurance documents, automobile registration, printout from IRS or Social Security Administration, certification documents from Food Stamps, Medicaid, or Chip, current voter's registration card, post office records.

❑ PROOF OF HOUSEHOLD COMPOSITION

You will need **proof of all members in your household**. Valid documents include: Birth certificate, most recent IRS 1040 form, Social Security Award letter for dependents, school documents, insurance documents, U.S. Immigration application, divorce or child support decree, birth fact record for newborns up to 90 days old, proof of school enrollment for students aged 18-23.

❑ PROOF OF HOUSEHOLD INCOME

You will need proof of **income for all household members** in the *past 30 days*, valid documents include: check stubs, wage verification letter, current year 1040 tax form if self-employed**,** pension, child support, social security, unemployment, workmen's compensation, retirement checks or statements**.** If no proof is provided, a bank statement or letter of support is acceptable.

❑ HEALTHCARE COVERAGE

You will need proof of other healthcare coverages, valid documents include: Insurance ID cards (Medicaid, Medicare, CHIP, CHIP Perinatal), award or claim letters, insurance policies, or court documents.

❑ VALID PHONE NUMBER

You must provide a working phone number where you can be reached. Examples: home, work, mobile, emergency contact or relative with whom we may leave a message.

Patient Portal
Online and FREE in the App Store

www.sbchc.net

NOTICE: If you are qualified for financial assistance and it is later determined that the information or proof you provided on this application is false, you may lose your financial assistance, may be barred from reapplying for six months, and be required to repay SBCHC for any services rendered.

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First:	Middle:	Alternative Names (if any):		
Home Address:		Apt/Suite:	City:	State:	ZIP Code:
Gender at Birth: ❑M ❑F	Date of Birth: / /	Email Address:	Phone Number: ( )		Marital Status: ❑Single ❑Married ❑Divorced ❑Other

Patients 18 years old and up, answer the following questions:

Sexual Orientation[1]:
❑Straight ❑Lesbian/Gay ❑Bisexual ❑Don't know
❑Something else ❑Choose not to disclose

Current Gender Identity[2]:
❑Male ❑Female ❑Choose not to disclose ❑Other
❑Transgender F (M-to-F) ❑Transgender M (F-to-M)

Preferred Language:
❑ English ❑Spanish ❑Vietnamese ❑Arabic ❑Other:_____

Are you a veteran of the U.S. Armed Forces?
❑Yes ❑No

Latino/Hispanic Descent:
❑Mexican/Mexican American/Chicano(a)
❑Puerto Rican ❑Cuban
❑Another Hispanic/Latino(a) Origin
*Please specify:*_____
❑ Non-Hispanic ❑ Decline to specify

Race: *Please select all that apply*
❑ White ❑ Black/African American ❑Asian Indian ❑Chinese ❑Filipino
❑Japanese ❑Korean ❑Vietnamese ❑Other Asian ❑ Native Hawaiian
❑Samoan ❑ Other Pacific Islander ❑Guamanian or Chamorro
❑ American Indian/Alaska Native ❑ Decline to Specify

How did you hear about us? ❑ Relative/Friend ❑ School ❑ Hospital ❑ Church ❑ TV ❑ Health Fair ❑ Internet
❑ Direct Mail/Flyer ❑ Radio ❑ Newspaper ❑ Magazine ❑ M.A.M. ❑ Other: _____

1: **Sexual orientation** is the term used to describe what gender(s) someone is sexually and/or romantically attracted to.
2: **Gender identity** is how we feel about and express our gender and gender roles — clothing, behavior, and personal appearance.

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name:	Relationship to Patient:	Address:	Phone Number: ( )

EMERGENCY CONTACT

Name:	Relationship to Patient:	Address:	Phone Number: ( )

PHARMACY INFORMATION

Name:	Address:	Phone Number: ( )

DEMOGRAPHIC INFORMATION

Do you own or rent your house/apartment? ❑ Yes ❑ No
If you answered no to the previous question, how would you describe your living situation in the past year?
❑ In a Shelter ❑ Live with a relative ❑ Transitional Housing ❑ On the Street ❑ Subsidized Housing

In the past 2 years, have you or anyone in your family worked in any type of agriculture (farm work)? ❑ Yes ❑ No
If yes, did you establish a temporary home? ❑ Yes ❑ No

Do you/your family worry about whether your food will run out and you will not be able to get more? ❑ Yes ❑ No

Are you worried about losing your housing? ❑ Yes ❑ No

Are you currently having issues at home with your utilities, such as your heat, electric, natural gas, or water? ❑ Yes ❑ No

Has a lack of transportation kept you from attending medical appointments, from work, or from getting things you need for daily living? ❑ Yes ❑ No

Are you worried that someone may hurt you/your family? ❑ Yes ❑ No

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I hereby authorize the following individual(s) to consent to treatment or services and to verbally give and receive protected health information regarding any treatment or services rendered at the clinic. If any changes occur to this authorization, it will be my responsibility to notify the clinic. Individuals listed below must be 18 years of age or older and have a picture I.D.

Name	D.O.B.	Relationship

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No (If you checked 'No', please skip this section) Please indicate primary insurance: ❑ Medicaid ❑ Medicare ❑ CHIP ❑ CHIP Perinatal ❑ Private Insurance:_____ ❑ Other: _____				
Person responsible for charges:	Birth Date: / /	Address (if different from above):		Home Phone Number: ( )
Subscriber's Insurance ID #:	Group Name:	Group Number:	Policy Number:	Co-Payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:_____				
Is this patient covered by a Secondary Insurance? ❑ Yes ❑ No				

CONSENT FOR MEDICAL TREATMENT

I agree to have medical care provided by Spring Branch Community Health Center providers and to follow their instructions regarding appointments and testing, which may be required. I do not hold the clinic or its employees responsible for any unusual effects resulting from their care.

The patient hereby authorizes and consents to any services, including but not limited to diagnostic procedures, radiology procedures, laboratory procedures, anesthesia medical or surgical treatments, and/or dental and mental health services, which are deemed necessary or advisable by the attending provider(s) and rendered to the patient under the general or special instructions of said provider(s).

_____
Initials

STATEMENT OF CONFIDENTIALITY

All information included in this interview and record is confidential and will be protected under the HIPAA Privacy Rule. We are informing you that we may use and disclose your protected information to carry out treatment, payment, or health care operations. I understand that for a more complete description of such uses and disclosures, I have the right to **review the "Notice of Privacy Rights**" prior to signing the consent. I understand that I have the right to request in writing restrictions on how my protected health information is used or disclosed. I understand the Center has the right to review and deny this request.

I understand that I may revoke this consent in writing, except to the extent that Spring Branch Community Health Center has taken action in reliance thereon.

_____
Initials

INSURANCE ASSIGNMENT

I hereby authorize payment of Medicaid/Medicare/Dental/Other Benefits otherwise payable to me, directly to Spring Branch Community Health Center. I also authorize the release of any information relating to any claim for myself or minors under my guardianship.

I understand that I am responsible for all costs of treatment to include any services not covered by my insurance benefits.

_____
Initials

I agree and understand the above Consent for Medical Treatment, Statement of Confidentiality, and Insurance Assignment.

_____ _____

Print Patient Name *Patient DOB*

_____ _____ _____

Patient/Guardian Signature *Relationship to Patient* *Date*

CONSENT TO RECEIVE SMS TEXT MESSAGES

By signing below, I authorize Spring Branch Community Health Center to contact me by SMS text message. (appointment reminders, center announcements, etc.)

Sign here to opt-in to texts: _____

Initial here if you do NOT wish to receive SMS text messages from SBCHC: _____

FOR OFFICE USE ONLY		
REVIEWED Staff Member Name *(print)*:_____	Date:_____	Signature: _____

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PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES

Welcome to our community health center. Our goal is to provide quality health care to qualified persons in the community, regardless of their ability to pay. As a patient, you have rights and responsibilities. The Center also has rights and responsibilities. We want you to understand these rights and responsibilities, so you can help us provide the best health care services for you. Please read and sign the below statement and do not hesitate to ask us any questions that you may have.

1. HUMAN RIGHTS

a. You have a right to be treated with respect regardless of race, color, marital status, religion, sex, sexual orientation, gender identity, national origin, ancestry, physical or mental handicap or disability, age, Vietnam-era veteran status, or other grounds not permitted by applicable federal, state, and local laws or regulations.

2. PAYMENT FOR SERVICES

a. You are responsible for giving us accurate information about your present financial status and any changes in your financial status. This information is needed to determine your eligibility for programs, discounts and insurance. If your income is less than the federal poverty guidelines, you will be charged a discounted fee.

b. You must pay, or arrange to pay, all agreed fees for health services as provided by our policies. You have a right to receive an explanation of the Center's bill. For any questions regarding our bill or statement, dial 713-462-6565, option 5.

c. Federal law prohibits us from denying you primary health care services which are medically necessary solely because you cannot pay for these health services at the time of your medical visit. If in the event you do not make any attempt to comply with your payment plan, we have the right to discontinue our services to you. For more information regarding payment plans, you may contact our billing department during Center's business hours at 713-462-6565, option 5.

3. PRIVACY

a. You have a right to have your interviews, examinations, and treatments in private. **Your medical records are also private.** Only legally authorized persons may see your records, unless you request in writing for us to show them to or copy them for someone else. Feel free to ask any questions regarding your privacy rights or request a copy of our "Notice of Client Privacy Rights." The Notice of Privacy Practices sets forth the way in which your medical records may be used or disclosed by the Center and the rights granted to you under the Health Insurance Portability and Accountability Act (HIPAA).

4. HEALTH CARE

a. 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.

b. You have a right to information and explanation in the language you normally speak and in words you understand. You have a right to information about your health, illness, and treatment plan including the nature of your treatment, its expected benefits, its inherent risks and hazards (and the consequences of refusing treatment), the reasonable alternatives, if any (and the risks and benefits), and expected outcome, if known. This information is called obtaining your informed consent.

c. You have the right to receive information regarding "Advance Directives". If you do not wish to receive this information but it is medically advisable to share the information with you, we will provide it to your legally authorized representative.

d. You are responsible for appropriate use of our services, which includes following staff's instructions, making and keeping scheduled appointments. If you cannot follow the staff's instructions, let us know so we can help you.

e. If you are an adult, you have the right to refuse treatment to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of your refusing such treatment or procedures. You are responsible for the outcome of refusing treatment.

f. You have the right to medical and dental care and treatment that is reasonable for your condition and within our capability; however, the Center is not an emergency care facility. You have the right to be transferred or referred to another facility for services we cannot provide. You're financially responsible for services received somewhere else.

g. If you are in pain, you have the right to receive an appropriate assessment and pain management as necessary.

h. **In order to improve your health outcomes, we believe self-management is vital.** You are encouraged to take an active role in your health care and be involved in decisions that pertain to your health care. We also encourage you to actively monitor your health and follow the advice of your provider to improve your health.

i. You have the right to a second opinion from a different health care provider. You may request a second opinion from another provider at our facility, or you may seek an opinion from a separate organization. If you feel your condition requires specialty care, you have the right to request a referral to a specialty care provider.

j. As a patient, we will assign you a Primary Care Provider. The selection may be defaulted based on your visit history. You have the right to request a certain Primary Care Provider and you may switch to another Primary Care Provider at any time that you feel necessary.

Patient Initials:_____ Patient DOB:_____/___/_____

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5. CENTER RULES - Please initial below.

_____a. You have the right to receive information on how to use the Center and its services. You are responsible for using the Center and its program sites in an appropriate manner. If you have any questions about services, please ask us.

_____b. You are responsible for the safety and supervision of children you bring to the Center. Children under the age of 14 cannot be left unattended at any time while in our facility.

_____c. You have a responsibility to keep your scheduled appointments. Missed appointments cause delay in treating other patients and prevent others from getting a timely appointment. It is your responsibility to inform the Center of any changes regarding your appointments and ability to attend to them. If you cannot attend your appointment, please call our Center to cancel at least 24 hours before your appointment time. If you do not show up to your appointment, your appointment will be marked as "No-Show". Two (2) "No-Shows" within 12-month will result in a "Chronic No-Show". "Chronic No-Show" patients can only be seen as walk-ins, on a first come first served basis only if time permits.

_____d. Failure to arrive on time can lead to rescheduling of the appointment for later in the day or for another day. Late arrivals can delay patient care for others. If the Center is unable to reschedule the appointment, the patient's appointment will be marked as "No-Show".

_____e. If you are a new patient or need to complete an annual registration renewal, you will need to schedule a visit with our Eligibility Specialists prior to your medical visit. Eligibility Specialists visits can be done same day as your medical visit, Eligibility Specialists appointments are based on their availability. If patient misses the Eligibility Specialists appointment, patient will not be able to see the medical/dental provider.

_____f. Please call your pharmacy first to request a refill of your medication. It is important that you do not let your medication run out before contacting the pharmacy. Due to the high volume of refill requests, please allow at least 3 business days from the day of the request for the clinical staff to refill your medications if a Provider approval is required.

_____g. Our clinics have 10 business days to review and publish your lab results to the patient portal. Please check your portal for results before calling the clinic.

_____h. If patients are in need of any medical documents (i.e. sport physical, school, disability, or other paperwork), please allow our clinics at least 10 business days from the day of request to complete the paperwork. Our clinics will contact you when paperwork is ready.

6. COMPLAINTS

a. If you are not satisfied with our services, please tell us. We welcome suggestions so we can improve our services. If you are not satisfied with how we handle your complaint, you may file a complaint with the Center's Executive Team. The Team will submit a report to the Board of Directors. We value you as a patient; your voice will be heard.

b. We will not punish, discriminate, or retaliate against you for filing a complaint, and will continue to provide you services.

7. TERMINATION

a. 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 thirty (30) days to find other health services. However, 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 patients. Other reasons for which we may stop seeing you include, but are not limited to: (A) Failure to obey rules, (B) Persistent failure to keep scheduled appointments, (C) Intentional failure to report accurate information concerning your health, (D) Intentional failure to follow the health care program, such as instructions about taking medications, personal health practices, or follow-up appointments, as recommended by your provider, (E) Manipulation of written medication prescription, (F) Creating a threat to the safety of the staff and/or other clients, (G) Intentional failure to accurately report your financial status, (H) Non-compliance with payment plan, and/or (I) Abusive, inappropriate, or violent behavior toward others (including staff or other patients) or the Center facilities that interferes with the Center's ability to deliver services reasonably to the patients. **The Center maintains <u>ZERO TOLERANCE</u> for abuse, harassment, or violence of any kind**. A person who causes or threatens to cause abuse, harassment, or violence of any kind is subject to immediate termination as a patient of the Center and/or removal from the Center premises. The Center will not give a 30-day termination notice in these situations. You have a right to receive a copy of the Center's termination policy.

8. APPEALS

a. If the Center has given you notice of termination, then you have the right to appeal the decision to the Center's Executive Team via email at compliance@sbchc.net. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

Patient Signature:_____Patient DOB:_____/____/_____ Date:_____/____/_____

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PRIMARY CARE MEDICAL HOME

A Patient-Provider Partnership

At Spring Branch Community Health Center, our primary goal is to provide the best possible care to every patient. The only way to meet this goal is to build a trusting partnership between an informed patient, the patient's provider, and the health care team. A medical home is a team approach to providing patients with the best health care.

To fulfill this partnership, we will:

- **Respect you as an individual**
  - Listen to your feelings and questions to help you make decisions and set healthy goals
  - Explain diseases, treatment, and results
  - Keep medical information and records private
- **Provide safe and qualified care**
  - Provide you with your own primary care provider
  - Provide clear directions about medicines and treatments
  - Send you to trusted experts, if needed
  - End every visit with clear instructions about expectations, treatment goals, medicines, and future plans
- **Strive to build flexibility to schedule you with your personal physician/provider whenever possible**
  - Provide 24-hour phone access to the health care team
  - For after-hours emergencies, dial 911. For all other non-urgent medical inquiries, you may call 713-462-6565, option 6
  - Online patient portal to view lab results, request refills, and schedule appointments

In return, we trust you to:

- **Be in charge of your health**
  - Learn about wellness and preventing diseases and make healthy decisions
  - Be honest and thorough about your history, symptoms, and any changes in your health
  - Tell us what medications you are taking and ask for refills during your office visit
  - Tell us when you see other doctors, medications they have prescribed, and ask them to send a report about your care
  - Learn what your insurance covers
- **Be a responsible patient**
  - Take all of your medicine and follow your treatment plan, or tell us if you cannot do so
  - Respect us as partners in your care
  - Keep your appointments as scheduled, or call and let us know if you need to cancel
  - Pay your share of the office visit fee when you are seen in the office
- **Communicate with us**
  - Ask questions, share feelings, be part of your care
  - Call the office before going into the emergency room
  - Provide us with feedback to improve services
  - End every visit with a clear understanding of your provider's expectations, treatment goals, and future plans

_____	___/___/_____	_____/___/_____
Print Patient Name	Patient DOB	Patient Signature	Date

_____	_____	___/___/_____
Provider/Provider Representative	Signature	Date

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TELEMEDICINE INFORMED CONSENT*

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Spring Branch Community Health Center at 713-462-6565.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for a quality review or audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____

Patient DOB

_____ _____

Witness Signature Date

*Texas Medical Association (2019)

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Greater Houston HEALTHCONNECT

PRISMA

PATIENT AUTHORIZATION FOR GREATER HOUSTON HEALTHCONNECT AND PRISMA

Spring Branch Community Health Center 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.

Spring Branch Community Health Center also participates in PRISMA, an eClinicalWorks based health information search engine. PRISMA gives your doctor the ability to search for your protected health information from other participants of PRISMA including other specialists, urgent cares or hospitals at point of care. A full list of participants are available at www.carequality.org & www.commonwellalliance.org.

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

Choosing not to join Healthconnect and PRISMA, does not affect your eligibility, benefits, and treatment.

This authorization remains in effect until the patient and/or patient caregiver revoke this authorization at any time by giving written notice to any healthcare provider who participates in Healthconnect or PRISMA. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect.

Printed Patient Name:_____ Patient DOB:_____

Signature of Authorized Person:_____ Date: _____

Printed Name (if different from Patient): _____

Relationship to Patient: _____

Initial here if you do **NOT** want your providers to see your records through Healthconnect and PRISMA: _____

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