Spring Branch
COMMUNITY HEALTH CENTER

Healthy Families. Healthy Community.

West Houston Clinic

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

Hours
Monday-Friday: 8am-5pm
2nd & 4th Saturday: 9am-1pm

Pitner Clinic

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

Hours
Mon, Wed, Fri: 8am-5pm
Tues & Thurs: 8am-8pm
1st & 3rd Saturday: 9am-1pm

Hillendahl Clinic

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

Hours
Monday-Friday: 8am-5pm

WholeLife Clinic

1839 Jacquelyn Road
Houston, TX 77055
(713) 462-6565

Hours
Monday-Friday: 8am-5pm

SPRING BRANCH COMMUNITY HEALTH CENTER

Visit us at any of our 4 locations or at our mobile clinic.

For more information and events, please visit us at:

www.sbchc.net

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SPRING BRANCH COMMUNITY HEALTH CENTER
REGISTRATION INFORMATION

Financial Assistance Program

The Financial Assistance Program is a special program to assist those who are uninsured or have difficulty paying for medical 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*:*

Your Responsibilities

You will be asked to bring proof of what you write on your application. The documents needed are as follows:

1. **YOUR IDENTITY AND IDENTITY OF FAMILY MEMBERS:**
   You will need proof of identity for you and your family members, which can include the following documents:
   a. 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

2. **WHERE YOU LIVE AND PLAN TO CONTINUE LIVING:**
   You will need one proof of residency, which can include the following documents:
   a. Dated within the past 60 days: utility bill, credit card statement, 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, school records for children, 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, letter from recognized social services agency, current voter's registration card, post office records, church records

3. **HOUSEHOLD COMPOSITION:**
   You will need proof of all members in your household, which can include the following documents:
   a. 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

4. **INCOME FOR ALL HOUSEHOLD MEMBERS IN THE PAST 30 DAYS:**
   You will need proof of income for all household members in the past 30 days, which can include the following documents:
   a. 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 will be needed.

5. **OTHER HEALTHCARE COVERAGE:**
   You will need proof of other healthcare coverages, which can include the following documents:
   a. Insurance ID cards (Medicaid, Medicare, CHIP, CHIP Perinatal) award or claim letters, insurance policies, court documents

6. **PHONE NUMBER WHERE YOU MAY BE REACHED:**
   You will need to provide a working phone number where you can be reached, which can include the following:
   a. Home, work, cell, emergency contact, neighbor, or relative with whom we may leave a message

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

(Please Print Clearly)

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

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)			
Name:	Relationship to Patient:	Address:	Phone Number: ( )

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

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 S.S. Number:	Group Name:	Group Number:	Policy Number:	Co-Payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:_____				

Secondary Insurance:	Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group Number:	Policy Number:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:_____					

Preferred Language: ❑ English ❑Spanish ❑Other:_____	Are you a veteran of the U.S. Armed Forces? ❑Yes ❑No	Are you currently homeless? ❑Yes ❑No
Race: ❑White ❑Asian ❑African American ❑Pacific Islander ❑American Indian ❑More than one race ❑Other: _____		Latino/Hispanic Descent: ❑Yes ❑No
Chose clinic because/referred to clinic by (please check one box): ❑ Relative/Friend ❑ School ❑ Hospital ❑ Church ❑ MAM ❑ Direct Mail ❑ TV ❑ Internet ❑ Magazine ❑Newspaper ❑ Radio ❑ 211 ❑ Other: _____		

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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

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).

_____
Initial

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 Client 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.

_____
Initial

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.

_____
Initial

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

_____
Patient Name

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

FOR OFFICE USE ONLY

Reviewed by: _____ Date: _____ Initial: _____

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PATIENT AND CENTER RIGHTS AND RESPONSIBILITES

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, 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. The staff needs this information to decide how much to charge you and/or so we can bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, you will be charged a discounted fee.
   b. You have a right to receive explanation of the Center's bill. You must pay, or arrange to pay, all agreed fees for health services as provided by our policies.
   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.

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. A complete discussion of your privacy rights will be given to you along with this document and is named "Notice of Privacy Practices." 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, or if it is not medically advisable to share that 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 and making and keeping scheduled appointments. We may not be able to see you unless you have an appointment. If you cannot follow the staff's instructions, please tell us 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 a 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 a right to be transferred or referred to another facility for services that we cannot provide. We do not pay for services that you get somewhere else.
   g. If you are in pain, you have a 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.

5. CENTER RULES:

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

b. You are responsible for the supervision of children you bring to the Center. You are responsible for their safety and the protection of other clients and our property. 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. If you cannot attend your appointment, please contact the clinic 24 hours prior to your appointment time to cancel. If you fail to show up to your appointment twice, you will no longer be given a slot on our schedule. You can only be seen as a walk in after that, on a first come first serve basis if time permits. It is your responsibility to provide 24 hours prior notice of cancellation. "Missed appointments" are defined as: (1) not showing up at scheduled appointments, or (2) not canceling your appointment 24 hours to your appointment time.

d. Our clinics have three business days to refill your prescription when you call in your prescription to us. Please do not wait until you are totally out of your medications to request refills; request your refills at least three business days before you run out of your medications.

6. COMPLAINTS:

a. If you are not satisfied with our services, please tell us. We want suggestions, so we can improve our services. We will tell you how to file a complaint. 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.

b. If you complain, no Center representative will punish, discriminate, or retaliate against you for filing a complaint; we 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, of 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. The Team will submit a report to the Board of Directors. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

Patient Signature: _____ 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

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 good 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

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Provider/Provider Representative	Signature	Date