OmniPoint Health
World-Class Care. Hometown Service.

Streamline your experience by using an online Patient Portal

A Patient Portal is a secure online website that gives patients convenient, 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information and much more!

Our primary care clinics also provide a convenient healow mobile app!

REQUEST & MANAGE APPOINTMENTS

COMMUNICATE WITH YOUR PROVIDER

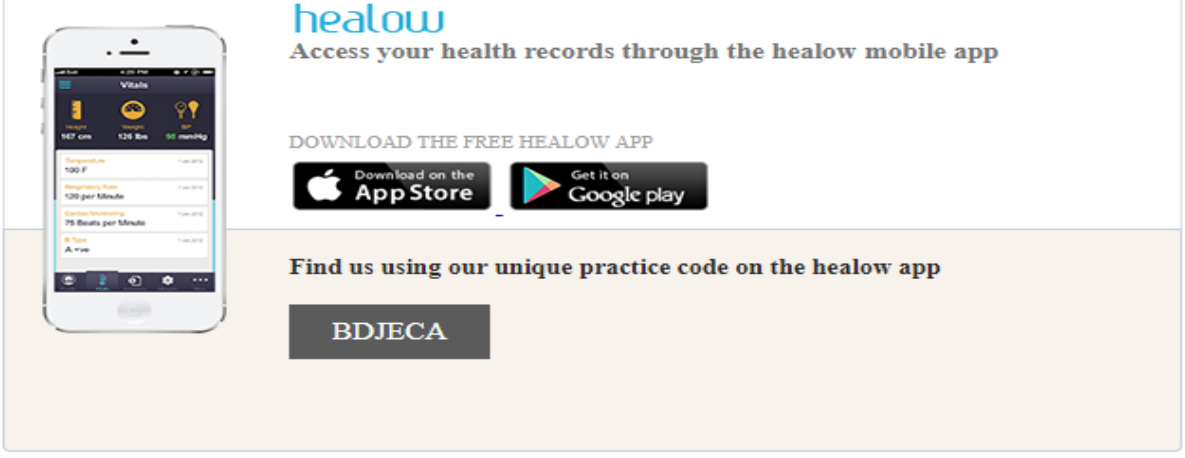
VIEW LAB & TEST RESULTS

VIEW STATEMENTS & MAKE PAYMENTS

To enroll, please provide your email address.
We will send you a link with your login information.

NAME:_____

EMAIL ADDRESS:_____



PATIENT INFORMATION / CONSENT FORM

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Patient Name: _____ **Date of Birth:** _____
Last, First Middle Initial

Mailing Address: _____
City State Zip Code

Home#: _____ **Cell #:** _____ **Work #:** _____

Email: _____ **Social Security #:**_____--_____--_____

Responsible Party: _____ **Relationship:** _____ **Phone#:**_____

Emergency Contact: _____ **Relationship**: _____ **Phone #**: _____

Sex:
- ☐ Male
- ☐ Female
- ☐ Transgender

Sexual Orientation:
- ☐ Lesbian, Gay, or Homosexual
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Do not know
- ☐ Choose not to disclose
- ☐ Something else:_____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

# of people in Household:
_____

Household Income:
- ☐ Under $20,000
- ☐ $20,00-$40,000
- ☐ $40,00-$80,000
- ☐ Over $80,000

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Female to Male/Transgender Male
- ☐ Male to Female/Transgender Female
- ☐ Genderqueer, neither male nor female
- ☐ Choose not to disclose
- ☐ Other: Describe_____

Language:
- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other:_____

Race: Check all that apply.
- ☐ White, Caucasian
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Unreported/Refused to Report

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused to Report

Disability:
- ☐ Yes
- ☐ No

Veteran:
- ☐ Yes
- ☐ No

Primary Insurance: _____ **ID #**_____ **Group #**_____

Policy Holder's Name: _____ **Policy Holder's DOB:** _____

Secondary Insurance: _____ **ID #**_____ **Group #**_____

Policy Holder's Name: _____ **Policy Holder's DOB:** _____

THE FOLLOWING CONSENTS REMAIN IN EFFECT UNTIL REVOKED IN WRITING

Authorization of Benefits to Provider: I understand that I am financially responsible for all charges incurred with OmniPoint Health, herein after referred to as 'Health Center.' I hereby assign and relinquish my interest in and title to my insurance benefits to the Health Center for all medical services rendered.

Acknowledgement of Receipt of Notice of Privacy Practices (NOPP): I hereby acknowledge that I have received a copy of the Notice of Privacy Practice for this facility and understand that I am giving my consent for the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. I realize that my records may be electronically transmitted (faxed) may not be received by the intended recipient. Should this occur, I release the Health Center from all liability.

Permit for Diagnosis and Treatment: I understand that presentation to the clinic is indicated by my condition or medical need. I voluntarily authorize and consent to the customary examinations, test, and procedures performed on patients in my condition and to routine medical treatment ordered by the Health Center's physician, physician's assistant, OR nurse practitioner.

PLEASE CIRCLE "YES" OR "NO" FOR THE FOLLOWING:		
I understand patient privacy laws apply to telehealth. I consent to receive services via **telehealth** appointments, when applicable.	**YES**	**NO**
I consent to join the secure health information exchange network, "**Greater Houston Health Connect**" (GHH), which electronically shares my protected health information with other participating providers and facilities.	**YES**	**NO**
I authorize the Health Center to take and/or use **photographs or electronic images** for the purpose of identity verification and/or my medical care.	**YES**	**NO**

_____ _____ **Date**_____ /_____ /20_____

Signature of Patient or Authorized Representative **Relationship to Patient**

PATIENT HISTORY

Date: _____

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Name *(Last, First, M.I.):*		**Date of Birth:**	
Previous or Current PCP Name:		**Pharmacy Name:**	
Previous or Current PCP Phone #:		**Pharmacy Phone #:**	

MEDICAL HISTORY

Are your immunizations up to date? **Yes** **No** **(INCLUDE SHOT RECORD FOR AGES 17 AND UNDER)**

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

☐ Acne / Skin Problems	☐ Bladder Infection	☐ Heart Disease	☐ Thyroid Problems	☐ Stomach / Intestinal Problems
☐ Asthma / Lung Disease	☐ Sexually Transmitted Disease	☐ High Blood Pressure	☐ Vision Problems	☐ Scoliosis / Back Problems
☐ Tuberculosis	☐ Headaches / Migraines	☐ Stroke	☐ Hearing Problems	☐ Pregnancy Problems
☐ Liver Disease	☐ Seizures / Epilepsy	☐ Heart Attack	☐ Sickle Cell Disease	☐ Blood Transfusions
☐ Hepatitis	☐ Cancer	☐ Diabetes	☐ Anemia	☐ Sleep Apnea

Please list other health conditions or concerns:

SOCIAL & BEHAVIORAL HISTORY

None ☐

☐ Low Self-Esteem	☐ Depression / Mood Swings	☐ Housing Issues	☐ Alcohol Abuse	☐ Legal Trouble
☐ Attempted Suicide	☐ Family Stressors	☐ Gang-Related Issues	☐ Drug User	☐ Physical / Emotional Abuse
☐ Trouble Sleeping	☐ Financial Problems	☐ Fad Diets	☐ Smoker	☐ Learning Problems

Are there any problems at home you would like to discuss with your provider? **Yes** **No**

Are you concerned about your safety at home? **Yes** **No**

SURGERIES / HOSPITALIZATIONS

None ☐

Age	Reason	Hospital

CURRENT MEDICATIONS

None ☐

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

ALLERGIES / DRUG INTOLERANCES

None ☐

Allergy / Intolerance	Reaction

FAMILY HISTORY

None ☐

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

	Mother	Father	Brother	Sister	Child	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Other, list:
Cancer										
Diabetes										
High Blood Pressure										
Stroke										
Heart Attack (< 55 years old)										
Thyroid Problems										
Tuberculosis										
Drug Abuse										
Alcohol Abuse										
Learning Problems										
Mental Illness										
Other:										

CHAMBERS COUNTY PUBLIC HOSPITAL DISTRICT #1

NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003

Revised June 2013

OmniPoint Health
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This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care treatment and billing-related information. This notice applies to all of the records of your care generated by OmniPoint Health.

Our Responsibilities:
We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this disclosure.

USES & DISCLOSURES:
How we may use and disclose Health Information about you. The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other clinic or hospital personnel who are involved in taking care of you at either facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third-party payer.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

We may also use and disclose health information: To business associates we have contracted with to perform the agreed upon service and billing for it; To remind you that you have an appointment for medical care; To assess your satisfaction with our services; To tell you about possible treatment alternatives; To tell you about health-related benefits or services; To contact you as part of fundraising efforts; To inform Funeral directors consistent with applicable law; For population based activities relating to improving health or reducing healthcare costs; and For conducting training programs or reviewing competence of healthcare professionals.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to; Food and Drug Administration, Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability, Correctional Institutions, Workers Compensation Agents, Organ and Tissue Donation Organizations, Military Command Authorities, Health Oversight Agencies, Funeral Directors, Coroners, and Medical Directors, National Security and Intelligence Agencies, Protective Services for the President and Others.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

- Inspect and Copy, Request an Amendment, Request an Accounting of Disclosures, Request Restrictions, Request Confidential Communications, and to Receive a Full Copy of This Notice.
- You may also print or view a copy of the Notice of Privacy Practices link at www.omnipointhealth.com.

To exercise any of your rights, please obtain required forms from the Privacy Officer & submit your request in writing.

CHANGES TO THIS NOTICE
We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in each Clinic and Hospital and include the effective date. In addition, each time you register at or are admitted to the surgery center for treatment or healthcare services as a patient, we would offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*

If you have any questions about this notice, please contact the Facility Privacy Officer at (409) 267-3143.