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

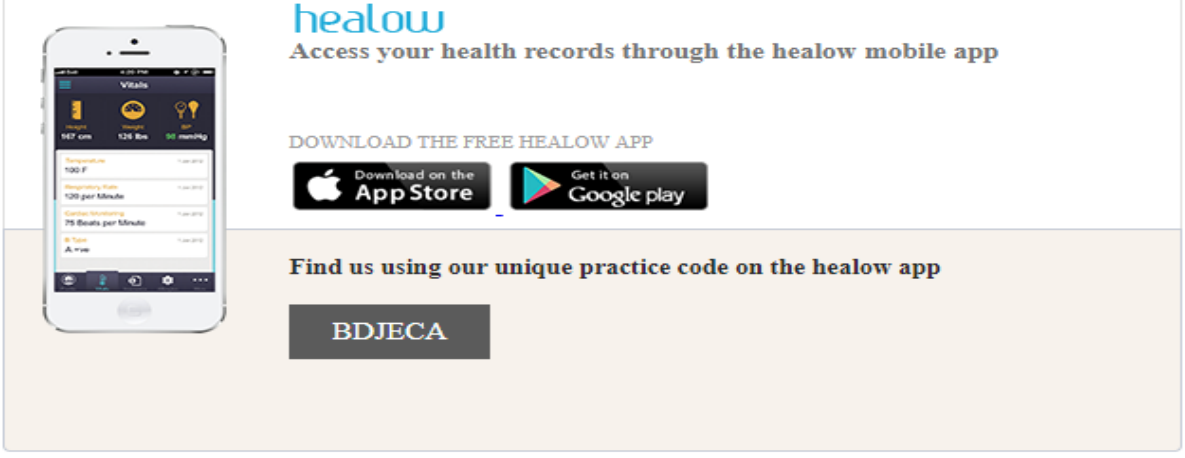
VIEW LAB & TEST RESULTS

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

OmniPoint Health
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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: _____

OmniPoint Health
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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:										

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Gender: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, the child's immunization information may by law be accessed by a public health district or local health department, for public health purposes within their areas of jurisdiction, a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient, a state agency having legal custody of the child, a Texas school or child-care facility in which the child is enrolled, and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.

Parent, legal guardian, or managing conservator:

Printed Name _____ Signature _____ Date _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Provider Statement

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Contact Information

Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com

Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: _____
   Last Name First Name MI
2. Child's Date of Birth: ____/____/____
   MM DD YYYY
3. Parent, Guardian, or Individual of Record: _____
   Last Name First Name MI
4. Primary Provider's Name: _____
   Last Name First Name MI
5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

** Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC-eligible children.*

**** Children enrolled in the State of Texas Children's Health Insurance Program (CHIP). An agreement between the DSHS Immunization Unit and CHIP stipulates that vaccines for eligible CHIP enrollees are purchased through the federal contract.*

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record
(Continued)

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

Medicaid:

Medicaid Number: _____

Date of Eligibility: _____

CHIP:

CHIP Number: _____

Group Number: _____

Date of Eligibility: _____

Private Insurance:

Name of Insurer: _____

Insurance Name: _____

Insurer Contact Number: _____

Policy or Subscriber Number: _____

CHAMBERS COUNTY PUBLIC HOSPITAL DISTRICT #1

NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003

Revised June 2013

OmniPoint Health
World-Class Care. Hometown Service.

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.

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Consent for Treatment of Minor Child Accompanied by Adult Substitute

I am a parent/legal guardian of

_____ _____, hereinafter
(Name of minor child) **(Date of birth)**
referred to as "**minor,**" and I agree as follows:

1. I authorize OmniPoint Health to;
   a. Provide medical (including immunizations), dental, or behavioral health treatment in my absence, which allows the **minor** to come to appointments accompanied by an Adult Substitute (see #2).
   b. Allow an Adult Substitute designated by me to give informed consent for emergency, urgent, and other medical, dental, or behavioral health care and treatment for the **minor.**

2. **Identification of Adult Substitute**. I appoint the following Adult Substitute(s) to give informed consent for care and treatment and acknowledge that they may receive limited access to the **minor's** protected health information to do so.

Authorized Adult Substitute(s)	Relationship to Minor	Phone Number

This authorization is valid until revoked in writing by providing notice to:
OmniPoint Health, P.O. Box 398, Anahuac, TX 77514.

I release OmniPoint Health from liability for any claims of lack of consent or insufficient consent with respect to any health care provided by OmniPoint Health pursuant to this Authorization for treatment of **Minor** Child and any use or disclosure of protected health information related to such treatment. I have carefully read and considered this consent form before signing it.

_____ _____
Name of Parent/Legal Guardian **Relationship to Minor Child**

_____ _____
Signature of Parent/Legal Guardian **Date**