Chambers Health
Chambers Community Health Centers

PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME | DATE OF BIRTH ☐☐ / ☐☐ / ☐☐☐☐

MAILING ADDRESS

(CITY) (STATE) (ZIP)

PHYSICAL ADDRESS

(CITY) (STATE) (ZIP)

PRIMARY PHONE ☐ HOME ☐ MOBILE | SECONDARY PHONE ☐ HOME ☐ MOBILE

EMAIL | SOCIAL SECURITY #

EMERGENCY CONTACT:

NAME | RELATIONSHIP | PHONE

Chambers Community Health Centers, Inc., a federally qualified health center, welcomes every member of our community and all the information we request in the following questions is for statistical purposes. This information is strictly confidential to the full extent permitted by law. The information below permits us to evaluate each patient for the programs and services we provide. Please answer as best as possible and feel free to ask any questions.

TOTAL # OF FAMILY HOUSEHOLD MEMBERS | GROSS ANNUAL HOUSEHOLD INCOME $

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED

SEX ☐ MALE ☐ FEMALE

DISABLED ☐ YES ☐ NO

VETERAN ☐ YES ☐ NO

ARE YOU HOMELESS? ☐ YES ☐ NO

IF YES, ☐ TRANSITIONAL ☐ DOUBLING UP ☐ STREET ☐ PERMANENT SUPPORTIVE HOUSING ☐ OTHER ☐ UNKNOWN

LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ VIETNAMESE ☐ OTHER

ETHNICITY ☐ MEXICAN/CHICANO(A) ☐ ANOTHER HISPANIC ☐ NOT HISPANIC ☐ PUERTO RICAN ☐ CUBAN

RACE

☐ WHITE ☐ FILIPINO ☐ KOREAN ☐ CHINESE
☐ BLACK/AFRICAN AMERICAN ☐ OTHER PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ GUAMANIAN/CHAMORRO
☐ JAPANESE ☐ SAMOAN ☐ ASIAN INDIAN ☐ OTHER ASIAN
☐ VIETNAMESE ☐ NATIVE HAWAIIAN ☐ MORE THAN 1 RACE ☐ CHOOSE NOT TO DISCLOSE

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? ☐ YES ☐ NO

IF YES, ☐ MEDICAID ☐ MEDICARE ☐ CHIP ☐ OTHER: _____ ☐ PRIVATE/COMMERCIAL

PRIMARY INSURANCE

MEMBER ID # | GROUP # | RELATIONSHIP TO SUBSCRIBER

(SELF, SPOUSE, CHILD, OTHER)

SUBSCRIBER NAME | DATE OF BIRTH ☐☐ / ☐☐ / ☐☐☐☐

SECONDARY INSURANCE

MEMBER ID # | GROUP # | RELATIONSHIP TO SUBSCRIBER

(SELF, SPOUSE, CHILD, OTHER)

SUBSCRIBER NAME | DATE OF BIRTH ☐☐ / ☐☐ / ☐☐☐☐

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting Chambers Health Privacy Officer.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

PATIENT NAME		DATE OF BIRTH	/ /
MAILING ADDRESS			
		(CITY)	(STATE) (ZIP)
PRIMARY PHONE	☐ HOME ☐ MOBILE	EMAIL	

I authorize the following person(s) to receive my personal health information, in my absence. I understand that this form will continue on file, and should I request to remove the listed individual(s) from my authorization list, I will submit a written request.

AUTHORIZED PERSON(S)	RELATIONSHIP TO PATIENT	PHONE NUMBER

This authorization is valid until revoked in writing.

By signing this form, I consent to Chambers Health's Use And Disclosure Of Protected Health Information about me for treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where Chambers Health has already made disclosures in reliance on my consent.

I release Chambers Health from liability for any claims of lack of consent or insufficient consent with respect to any services provided by Chambers Health pursuant to this authorization for Use And Disclosure Of Protected Health Information related to such treatment.

I certify that I have read this form or have had it read to me, and I understand its contents and agree to the above information.

_____ _____ _____/_____/_____

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

Witness signature required when signed by Authorized Representative of Patient.

_____ _____ _____/_____/_____

Signature of Witness **Printed Name of Witness** **Date**

Chambers Health
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PATIENT REGISTRATION

PATIENT HISTORY

PATIENT NAME _____ **DATE OF BIRTH** __ __ / __ __ / __ __ __ __

MEDICAL HISTORY

PLEASE MARK IF YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS:

☐ ACNE / SKIN PROBLEMS	☐ BLADDER INFECTION	☐ HEART DISEASE	☐ THYROID PROBLEMS	☐ STOMACH / INTESTINAL PROBLEMS
☐ ASTHMA / LUNG DISEASE	☐ SLEEP APNEA	☐ CANCER	☐ 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	☐ HIGH BLOOD PRESSURE	☐ DIABETES	☐ ANEMIA	☐ SEXUALLY TRANSMITTED DISEASE

PLEASE LIST OTHER HEALTH CONDITIONS OR CONCERNS: _____

BEHAVIORAL / SOCIAL HISTORY

☐ LOW SELF-ESTEEM	☐ LEGAL TROUBLE	☐ HOUSING ISSUES	☐ FAD DIETS	☐ DEPRESSION / MOOD SWINGS
☐ ATTEMPTED SUICIDE	☐ FAMILY STRESSORS	☐ GANG-RELATED ISSUES	☐ DRUG USER	☐ PHYSICAL / EMOTIONAL ABUSE
☐ TROUBLE SLEEPING	☐ FINANCIAL PROBLEMS	☐ ALCOHOL ABUSE	☐ 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

AGE	REASON	HOSPITAL

CURRENT MEDICATIONS

PRESCRIPTION / VITAMIN / SUPPLEMENT / OTC MEDICATION	STRENGTH / DOSE	FREQUENCY TAKEN

ALLERGIES

ALLERGY / INTOLERANCE	REACTION

FAMILY HISTORY

PLEASE MARK IF ANYONE IN YOUR FAMILY HAS/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 YRS) OLD)										
THYROID PROBLEMS										
TUBERCULOSIS										
DRUG ABUSE										
ALCOHOL ABUSE										
LEARNING PROBLEMS										
MENTAL ILLNESS										
OTHER:										

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CONSENTS AND ACKNOWLEDGEMENTS

_____ **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP):** I hereby acknowledge that I have received 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) and may not be received by the intended recipient. Should this occur, I release the Health Center from all liability.

_____ **ACKNOWLEDGMENT OF RECEIPT OF RIGHTS AND RESPONSIBILITIES:** I hereby acknowledge that I have received a copy of the Patient and Health Center Rights and Responsibilities and understand that I am giving my consent to abide by the terms and obligations.

_____ **ACKNOWLEDGMENT OF RECEIPT OF NONDISCRIMENATION NOTICE:** I hereby acknowledge that I have received a copy of the Non-Discrimination Notice for this facility and understand Chambers Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Chambers Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

_____ **CONSENT FOR TREATMENT**: I hereby consent to receive health care from Chambers Health physicians, physician's assistant, nurse practitioner, employees and such associates, assistants and other health care providers as my care team deems necessary. This care may include, but is not limited to, assessments, treatments, examinations, diagnostic or laboratory procedures (which may include HIV testing), administration of injections and/or medications, and other routine medical, nursing or dental care.

I have been informed and understand that this facility is affiliated with teaching institutions, and the services performed require observation, cooperation, and involvement of multiple health care providers. I authorize residents and/or students to participate in my care; however, I have the right to request a physician. I understand that I may revoke this consent at any time, except for services I have already received.

_____ **AUTHORIZATION OF BENEFITS TO PROVIDER:** I understand that I am financially responsible for all charges incurred with Chambers Health. I hereby assign and relinquish my interest in and title to my insurance benefits to Chambers Health for all medical services rendered.

_____ **FINANCIAL RESPONSIBILITY**: I agree to pay all charges for any health care services that are not covered or collected from my insurance carrier or other third-party payer, including any deductibles and coinsurance amounts. I understand that if I qualify for services through a grant funded program these resources are payers of last resort. As payers of last resort, grant-funded programs may not continue my eligibility if I currently or in the future have Medicare, Medicaid and/or third-party insurance coverage.

_____ **COMMUNICATION:** I understand that my email address and other contact information that I have provided will be used by Chambers Health for various purposes including, but not limited to, appointment reminders, prescription medication refill reminders, and registration for the patient portal. The secure patient portal allows patients to communicate with their health care providers and access some information in their medical records such as medication lists, certain laboratory results, and immunization records, however, these features may change from time to time. I understand that my email address will be used by Chambers Health to create a secure portal account for me, but that I will be required to establish my login information in order to access the portal.

_____ **PHOTOGRAPHS:** I authorize Chambers Health to take and/or use photographs and electronic images for purposes of identity verification and/or my medical records.

_____ **GREATER HOUSTON HEALTHCONNECT CONSENT:** Chambers Health participates in Health connect; a non-profit organization that provides a secure electronic network for Health connect participants. A list of current Health connect participants is available at www.ghhconnect.org.

Chambers Health's participation with others in GHHC, such as labs, pharmacies, radiology centers, doctors' offices, hospitals, and health insurers, permits Chambers Health to access, and utilize in providing care to you, any available electronic health information related to you. All GHHC participants must protect your privacy in accordance with state and federal laws. Your treatment and eligibility for benefits will not be affected. By my signature below, I agree that GHHC and its current and future participants, including Chambers Health, may use and disclose my protected health information electronically for the limited purposes of treatment, payment and health care operations. I understand that GHHC may connect to other health information exchanges in Texas and across the country that also must protect my protected health information in accordance with state and federal laws, and I authorize GHHC to share my information with those exchanges for the same limited purposes of treatment, payment and health care operations. This authorization remains in effect unless and until I revoke it. I understand that I can revoke this authorization at any time by giving written notice to any healthcare provider who participates in GHHC, and my revocation will be effective within three (3) days. I also understand that revoking this authorization does not affect information previously shared when my authorization was in effect. If you choose not to participate in programs, you should notify the in writing by emailing or providing a written statement in person to the Chambers Health Privacy Officer @ BStrickland@chambershealth.org.

The above consents remain in effect until revoked in writing.

I certify that I have read this form or have had it read to me, and I understand its contents and agree to the above information.

_____ _____ _____/_____/_____

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

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TELEHEALTH CONSENT AND ACKNOWLEDGEMENTS

The following information is provided to patients who are seeking Telehealth/Telemedicine services with Chambers Health. Telehealth involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telehealth allows the provider to see and communicate with the patient in real time.

_____ **CONSENT FOR TREATMENT**: I voluntarily request Chambers Health providers and physician(s) and such associates, residents, technical assistants and other health care providers as they may deem necessary to participate in my medical care using telehealth.

I understand that Chambers Health Telehealth Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. As such, the limitations of audio/video technology may limit the elements of physical exam that can be performed due to the nature of audiovisual technologies.

I acknowledge that Chambers Health Telehealth Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions.

I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability.

I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

I understand I have the right to refuse to participate or decide to stop participating in a telemedicine/telehealth visit at any time.

_____ **POSSIBLE LIMITATIONS: I**f Chambers Health Telehealth Providers determine that the telehealth services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telehealth session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented, or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment or worsening of symptoms after a telehealth session, I should alert my provider and, in the case of emergencies, dial 911, or go to the nearest hospital emergency department.

_____ **RELEASE OF INFORMATION:** To facilitate the provision of care and/or treatment through telehealth, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to Chambers Health Telehealth Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information: 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

I understand that the disclosure of my medical information to Chambers Health Telehealth Providers, including audio and/or video, will be via electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

_____ **PHOTOGRAPHS:** I understand that it may be necessary during the telehealth visit for the provider or provider office staff to take a picture within the telehealth platform to document my attendance and any condition specific issues (i.e. rash). These pictures will only be used for the purposes of documentation within the health record and are not saved by the provider or staff. I consent to having pictures taken for these purposes during the telehealth visit.

_____ **SYSTEM SECURITY:** Chambers Health routinely uses secure audio and video technology within the EHR platform. I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services.

I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations. I understand that there will be no video recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

The above consents remain in effect until revoked in writing.

I certify that I have read this form or have had it read to me, and I understand its contents and agree to the above information.

_____ _____ _____/_____/_____

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

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

Texas Immunization Registry (ImmTrac2)
Adult Consent Form

First Name _____ Middle Name _____ Last Name _____

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

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

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

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Other

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 immunization records. With your consent, your immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your immunization history to ensure that important vaccines are not missed. Visit Texas Health and Safety Code Sec. 161.007 (d) at statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007 for more information.

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

I understand that, by granting the consent below, I am authorizing release of my 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, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. 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. Visit Texas Health and Safety Code Sec. 161.00705 at statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705 for more information.

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ **I am a FIRST RESPONDER.** ☐ **I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.**

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

Individual (or individual's legally authorized representative):

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. Visit dshs.state.tx.us/sites/default/files/hipaa/docs/DSHS-NPP-English-5-1-2022.pdf for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • dshs.texas.gov/immunizations
Texas Department of State Health Services • Immunization Section • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunization Section

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