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 ☐☐ / ☐☐ / ☐☐☐☐

Chambers Health
Chambers Community Health Centers

PATIENT REGISTRATION

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
Chambers Community Health Centers

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:										

Chambers Health
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PATIENT REGISTRATION

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**

Chambers Health
Chambers Community Health Centers

PATIENT REGISTRATION

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

Stock No. F11-13366
Revised 09/2024

CHAMBERS COUNTY PUBLIC HOSPITAL DISTRICT #1
CHAMBERS COMMUNITY HEALTH CENTERS, INC.
NOTICE OF PRIVACY PRACTICES
EFFECTIVE APRIL 14, 2003

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 clinic, 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 the facilities listed.

Bayside Clinic	**Dayton Medical Center**	**West Chambers Medical Center**
621 South Ross Sterling	101 S. Prairie St	9825 Eagle Drive
Anahuac, Texas 77514	Dayton, Texas 77535	Mont Belvieu, Texas 77523
(409) 267-4126	(936) 340-5117	(281) 576-0670

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your health information; notify you following a breach of your unsecured health information; and provide 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 with 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 our facilities. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments may share health information about you to coordinate your care, such as prescriptions, lab work, and x-rays.
- **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 example, we may need to give your health plan information about care you received so they will pay us or reimburse you.
- **For Healthcare Operations:** We may use and disclose health information about you for our operations. These uses are necessary to run our facilities and ensure quality care. For example, we may use health information to review our treatment and services and evaluate the performance of our staff in caring for you.

Additional uses and disclosures of health information.

- **As Required by Law:** We will disclose health information about you when required to do so by federal, state or local laws or regulations.
- **Appointment And Patient Recall Reminders:** We may use and disclose your health information to contact you to remind you regarding appointments or for health care that you are to receive.
- **Sign-In Sheet:** We may use and disclose health information about you by having you sign in when you arrive at the Center. We may also call out your name when you are ready to be seen.
- **Business Associates:** Some of our functions are accomplished through contracted services provided by Business Associates. A Business Associate may include any individual or entity that receives your health information from us in the course of performing services for the Center. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

- **Disaster Relief:** We may disclose information about you to an entity assisting in disaster relief so that your family can be notified about your condition, status and location.
- **Health-Related Benefits or Services**: We may use and disclose health information to tell you about our health-related products or services and possible treatment alternatives that may be of interest to you.
- **Training:** When we conduct training programs and review competencies of healthcare professionals.
- **Individuals Involved in Your Care**: We may disclose health information to a family member, friend, or other person involved in your care or payment for care. If you are available, we will give you an opportunity to object. In emergencies or if you are incapacitated, we will use our professional judgment.
- **Research:** We may use and disclose health information about you for research purposes when an institutional review board or privacy board has reviewed the research proposal and protocols to ensure the privacy of your health information.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, we may notify emergency response personnel about a possible exposure to Acquired Immune Deficiency Syndrome (AIDS) and/or the Human Immunodeficiency Virus (HIV). Any such disclosure, however, would only be to the extent required or permitted by federal, state or local laws and regulations.
- **Change of Ownership:** In the event the Center is sold or merged with another organization, your health information/medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another Center, medical group, physician or other healthcare provider.

Special Situations

- **Funeral Directors, Coroners and Medical Examiners**: We may disclose your health information to funeral directors as necessary to carry out their duties. We may also disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Oversight Activities:** We may disclose your health information to a health oversight agency for activities authorized by federal, state or local laws and regulations. These oversight activities include, for example, audits, inspections, licensure reviews, investigations into illegal conduct, and compliance with other laws and regulations. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Public Health Activities:** We may disclose health information for public health activities, including Disease prevention and control, Reporting births and deaths, Reporting child abuse or neglect, Reporting reactions to medications or product problems, notifying people of product recalls, notifying someone who may have been exposed to a disease.
- **FDA:** We may disclose health information to the Food and Drug Administration related to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information.
- **Inmates**: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the institution or law enforcement official, if the disclosure is necessary (a) for the institution to provide you with health care; (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.
- **Law Enforcement:** We may release your health information if asked to do so by a law enforcement official in the following circumstances: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect fugitive, material witness, or missing person; (c) about the victim of a crime, if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) about a death we believe may be the result of criminal conduct; (e) about criminal conduct at the Center; or

(f) in emergency situations to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Lawsuits and Disputes**: If you are involved in a lawsuit or a dispute, we may disclose your health information to the extent expressly authorized by a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request (which may include written notice to you) and you have not objected, or to obtain an order protecting the information requested.
- **Military and Veterans:** If you are a member of the armed forces, we may release health information about you as required by military authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- **National Security and Intelligence Activities:** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Organ and Tissue Procurement Organizations:** If you are an organ donor, we may disclose health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.
- **Protective Services for The President and Others:** We may disclose health information about you to authorize federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.
- **Victims of Abuse, Neglect or Domestic Violence:** We may disclose your health information to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure when required or authorized by law.
- **Workers' Compensation:** We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Security Clearances:** We may use health information about you to make decisions regarding your medical suitability for security clearance or service abroad. We may also release your medical suitability determination to the officials in the Department of State who need access to that information for these purposes.
- **Multidisciplinary Personnel Teams:** We may disclose health information to a state or local government agency or a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

SPECIAL PROTECTIONS FOR CERTAIN TYPES OF INFORMATION

In some circumstances, your health information may be subject to additional restrictions that may limit or preclude some uses or disclosures described in this Notice or Privacy Practices. There are special restrictions on the use and/or disclosure of certain categories of health information such as:

- **Substance Use Disorder Treatment Records:** If you receive substance use disorder treatment services, your records have additional federal protections under 42 CFR Part 2. We will obtain your written consent before disclosing these records except in limited circumstances such as medical emergencies, court orders, or as permitted by law. You have the right to request restrictions on disclosures and an accounting of disclosures of these records.
- **Mental Health and Psychotherapy Notes:** If you receive mental health services, we may maintain psychotherapy notes about your counseling sessions. Psychotherapy notes are notes recorded by your mental health professional documenting or analyzing the contents of conversation during a private counseling session. Most uses and disclosures of psychotherapy notes require your specific written authorization. We cannot use or disclose these notes for treatment, payment, or healthcare operations without your authorization, except in very limited circumstances permitted by law.
- **HIV/AIDS Information**: Special restrictions apply to HIV/AIDS test results and treatment information. We will comply with state and federal laws requiring special handling of this information.

- **Genetic Information:** We are prohibited from using genetic information for underwriting purposes and will protect genetic information according to applicable laws.

In addition, Government health benefit programs, such as Medicare or Medicaid, may also limit the disclosure of patient information for purposes unrelated to the program.

REPRODUCTIVE HEALTH CARE INFORMATION USES AND DISCLOSURES REQUIRING ATTESTATION

By law, if we collect, receive, or maintain health information that is potentially related to your reproductive health care, in some cases we must obtain an attestation from health information recipients that they will not use or share that information for a purpose prohibited by law. The following situations require attestation:

- **Health Oversight Activities:** We may share your reproductive health care information for health oversight agency audits or inspections, civil or criminal investigations or proceedings, or licensure actions.
- **Judicial And Administrative Proceedings**: We may share your reproductive health care information in response to a court or administrative order, subpoena, or discovery request.
- **Law Enforcement Purposes:** We may share your reproductive health care information for law enforcement purposes, including in response to a court-ordered warrant or a law enforcement official's request for information about a victim of a crime.
- **Coroners or Medical Examiners:** We may share your reproductive health care information in some situations to a coroner or medical examiner to identify a deceased person, determine cause of death, or other duties as authorized by law.

We presume reproductive health care is lawful and will not use or disclose your reproductive health care information to investigate, sue, or prosecute you, any person who performed or assisted with your reproductive health care, or any person who helped you access reproductive health care, unless we have actual knowledge the care was unlawful.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

The following uses and disclosures will only be made with your written authorization:

- Sale of health information
- Most uses and disclosures of psychotherapy notes
- Uses and disclosures for marketing purposes (except face-to-face communications or promotional gifts of nominal value)
- Fundraising (you have the right to opt out)
- Other uses and disclosures not described in this notice

You may revoke your authorization at any time in writing, except to the extent we have already acted based on your authorization.

MARKETING AND FUNDRAISING

Marketing: We will not use or disclose your health information for marketing purposes without your written authorization. Marketing does not include face-to-face marketing communications with you or promotional gifts of nominal value that we may provide.

Fundraising: We may use certain information (such as your name, address, phone number, dates you received treatment, department of service, treating physician, outcome information, and health insurance status) to contact you for fundraising purposes. **You have the right to opt out of receiving fundraising communications.** Each fundraising communication will include clear instructions on how to opt out of future fundraising communications. If you opt out, we will not contact you for fundraising purposes in the future.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the following rights regarding your health information:

- **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of your health information that may be used to make decisions about your care. We will respond to your request within 15 days, which may be extended by an additional 30 days if we notify you of the delay. We may charge a reasonable fee for copying costs.
- **Right to Electronic Access:** If we maintain your health information electronically, you have the right to obtain an electronic copy in the format you request, if readily producible, or in another electronic format we agree upon.
- **Right to Request an Amendment:** If you believe health information, we have about you is incorrect or incomplete, you may ask us to amend the information. We will respond within 60 days of your request.
- **Right to an Accounting of Disclosures:** You have the right to request a list of disclosures we made of your health information for purposes other than treatment, payment, healthcare operations, and certain other activities.
- **Right to Request Restrictions:** You have the right to request restrictions on how we use or disclose your health information for treatment, payment, or healthcare operations. We are not required to agree to your request except: **if you pay out-of-pocket in full for a healthcare item or service, you can ask us not to share information about that item or service with your health insurer, and we must honor that request.**
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location if you clearly state that disclosure of all or part of the information could endanger you.
- **Right to Direct Transmission to Third Parties:** You have the right to request that we transmit your health information directly to a third party you designate.
- **Right to Notification of Breach:** If there is a breach of your unsecured protected health information that could result in significant risk of financial, reputational, or other harm to you, we will notify you in writing within 60 days of our discovery of the breach. The notification will include a description of what happened, the types of information involved, steps we are taking to investigate and mitigate the breach, and steps you can take to protect yourself from potential harm.
- **Right to a Copy of This Notice:** You have the right to obtain a copy of this notice. You may also view a copy at www.chambershealth.org.
- **Right to File a Complaint:** You have the right to file a complaint if you believe your privacy rights have been violated. **You will not be retaliated against for filing a complaint.**

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

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in the doctor's office, clinic, or hospital.

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 facility 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. **You will not be penalized for filing a complaint.**

To file a complaint directly with us:

Chambers County Public Hospital District #1
Attn: Privacy Officer
P.O. Box 398 Anahuac, Texas 77514
Phone: (409) 267-3143
Anonymous Hotline: 1 (888) 986-7962

To file a complaint with the State of Texas:

Health and Human Services Texas (Medicare/CMS)
P. O. Box 13247
Austin, TX 78711-3247
Phone Number: 1-800-458-9858, Option 1
Fax:1-888-780-8099 or 833-709-5735
Email: hfc.complaints@hhs.texas.gov

HHS Office of the Ombudsman
P.O. Box 13247
Austin, TX 78711-3247
Phone Number: 1-800-252-2412 or 877-787-8999
Fax: 1-888-780-8099
Email: ltc.ombudsman@hhsc.state.tx.us

Texas Behavioral Health Executive Council
George H.W. Bush State Office Building
1801 Congress Ave., Ste. 7.300
Austin, TX 78701
Phone Number: 1-800-821-3205

Texas State Board of Dental Examiners
333 Guadelupe Street
Austin, TX 78701
Phone Number: 1-800-821-3205

To file a complaint with the Federal Government:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W. Washington, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)
Website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Please see the separate form for Civil Rights (Section 1557).

If you have any questions about this notice, please contact the Facility Privacy Officer at (409) 267-3143, Monday -Friday, 8am – 5pm.

Visit us at www.chambershealth.org

Chambers Health
Chambers Community Health Centers

PATIENT INFORMATION

Chambers Health Non-Discrimination Notice
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).

Services Provided by Chambers Health

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
  - If you need these services, contact LaDuska M. James, Civil Rights Coordinator.

Filing a Grievance

If you believe that Chambers Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

LaDuska M. James, Civil Rights Coordinator
PO Box 398, Anahuac, TX 77514
Office: (346) 567-4839
Fax: (409) 267-4443
Email: LJames@ChambersHealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, LaDuska M. James, Civil Rights Coordinator, is available to help you. If you prefer to make an anonymous complaint, call the Compliance Hotline at 1-888-986-7962.

Filing a Civil Rights Complaint

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

PATIENT AND CHAMBERS HEALTH RIGHTS AND RESPONSIBILITIES

Our goal is to provide quality health care to people in this 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 better health care for you. Please read and sign this statement and ask us questions you might have.

Your Rights as a Patient

Nondiscrimination. You have a right to be treated with respect regardless of race, color, marital status, religion, sex (including pregnancy, sexual orientation, and gender identity), national origin, ancestry, physical or mental handicap or disability, age, veteran status, or other grounds as applicable federal, state and local laws or regulations.

Payment. You have a right to receive explanations of the center's bill.

While all patients of federally qualified health centers are expected to financially participate in their heath visits, Chambers Health offers eligibility screening for various state and federal programs that assist with health visit cost. Patients who are at or below 200% of the federal poverty guidelines and are deemed eligible will be informed of their appropriate office visit nominal fee at the time of eligibility.

You have the right to financial counseling services to help determine your eligibility for various assistance programs including Medicaid, CHIP, Health Insurance Marketplace plans, and other state or federal programs.

Privacy and Confidentiality. You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private. You have the right to receive a complete discussion of your privacy rights as our patient in the form of our "Notice of Patient Privacy Rights;" this document provides a comprehensive review of the ways in which we may use or disclose your medical records. By signing the "Patient and Chambers Health Rights and Responsibilities" you are acknowledging that you have received and understood our "Notice of Patient Privacy Rights."

Interpreter and Accessibility Services. You have a right to information and explanations in the language you normally speak and in words that you understand. You have the right to an interpreter who speaks your language at no cost to you. If you have a hearing or speech impairment, you have the right to communication services that meet your needs. You have the right to reasonable accommodations for disabilities to ensure equal access to our services.

Healthcare and Treatment. You have a right, and are encouraged, to participate in decisions about your treatment.

You have a right to information about your health or illness, 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 their risks and benefits); and the expected outcome, if known. This information is called obtaining your informed consent.

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.

If you are an adult, you have a right to refuse treatment or procedures 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. Your receipt of this information is necessary so that your refusal will be "informed."

PATIENT AND CHAMBERS HEALTH RIGHTS AND RESPONSIBILITIES – *cont'd*

You have a right to health care and treatment that is reasonable for your condition and within our capability. Chambers Health is a primary care facility and not an emergency room. In case of a medical emergency occurring on our premises, we will provide immediate stabilizing care and arrange for emergency transport if needed.

You have a right to be transferred or referred to another facility for services that the center cannot provide. The center does not pay for services that you receive from another healthcare provider.

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

Governance Participation. You have the right to participate in the selection process of the governing board for the Federally Qualified Health Center. Information about board meetings, elections, and how to become involved is available. Please ask to speak to Administrator for more information.

Quality Assurance. You have the right to participate in quality improvement activities, patient satisfaction surveys, and care evaluations. Your participation in these activities will not affect the quality or availability of your care in any way.

Services and Information. You have the right to receive information on how to appropriately use Chambers Health's services, including our hours of operation, available services, and how to access care. If you have any questions, please ask us.

You have the right to receive Chambers Health's "No Show Policy".

You have the right to culturally competent care that respects your cultural background, beliefs, and practices.

Termination. You have the right to receive Chambers Health's "Patient Discontinuance Policy," as you are expected to follow it.

If Chambers Health decides that we must stop treating you as a patient, you have the right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find another primary care provider. If Chambers Health has given you notice of termination, you have the right to appeal the decision to the Medical Director.

Complaints. You have the right to tell us how we can improve the services that we offer you. Chambers Health staff can let you know how to make a suggestion or file a complaint. If you are not satisfied with how the staff handles your situation, you may contact Chambers Health's administration.

Although we encourage you to bring your concerns directly to us, you always have the right to take any complaints to the Texas Department of State Health Services or Health and Human Services.

<u>Your Responsibilities as Patient</u>

Payment. You have the responsibility to give staff accurate information about your present insurance and/or financial status, as well as any changes in your insurance and/or financial status. Chambers Health staff needs this information to determine your financial responsibility and/or so they can bill private insurance, Medicaid, Medicare, or determine other benefits for which you might be eligible. If your income is less than the federal poverty guidelines, you could be charged a nominal fee. It is your responsibility to pay, or arrange to pay, all agreed fees for medical services, with the exception of dental services, which are provided on a prepaid basis. If you cannot pay right away, please let staff know so they can provide care for you now and arrangements can be made.

PATIENT AND CHAMBERS HEALTH RIGHTS AND RESPONSIBILITIES – cont'd

Privacy and Confidentiality. You have the responsibility of informing us of the people, if any, that may or may not access your medical records. It is important that we know this information from the beginning of your relationship with us so that we can avoid any future confusion. Chambers Health staff can provide you with a form to indicate those people you are granting access to your private medical record.

If you are a parent or legal guardian, please let staff know if someone other than yourself or child's legal guardian may be bringing the child to receive services.

Health Care Participation. You are responsible for providing complete and current information about your health or illness, including all medications, supplements, and treatments you are receiving from other providers, so that we can give you proper health care.

You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in your best interest, you may be asked to sign an Against Medical Advice form (as appropriate).

You are responsible for appropriate use of center services, which includes following staff instructions, making and keeping scheduled appointments, and requesting a "walk in" appointment only when you are ill.

You are responsible for following Chambers Health's "No Show Policy."

Scheduling and Appointments. We offer same-day appointments for established patients of the health center and do our best to see patients on a walk-in basis when possible. Please note, our providers are scheduled to see patients by appointment all day long so if you arrive to a clinic requesting to be seen as a walk-in, you may be waiting for an extended period of time. While we strive to provide care to as many patients as possible, you may not be seen without an appointment and asked to schedule an appointment for a future date.

You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments, you may be subject to disciplinary action pursuant to the Chambers Health's policies and procedures. Please refer to the No Show Policy.

Supervision of Children. You are responsible for the supervision of children you bring with you. You are responsible for your children's safety and the protection of other patients and our property.

Respectful Behavior. You have the responsibility to use Chambers Health's services in an appropriate manner. This means you must conduct yourself respectfully to all staff and fellow patients at all times while you are accessing clinical services. Threatening, abusive, violent, fraudulent, intentionally offensive, or any unlawful behavior will not be tolerated. If your behavior is deemed to consistently or permanently disrupt the relationship between your healthcare provider and yourself, then your relationship to Chambers Health may be terminated pursuant to Chambers Health's policies and procedures.

You and your visitors have a responsibility to treat the people who take care of you, other patients, and our property with respect and courtesy. You are responsible for respect for the privacy of others; limiting your use of cell phones in patient care areas and to ***NOT*** taking pictures or recording conversations without approval from staff.

PATIENT AND CHAMBERS HEALTH RIGHTS AND RESPONSIBILITIES – cont'd

Rights as Your Provider

Privacy and Legal Disclosures. In certain instances, Chambers Health may be required to disclose your medical records to State or Federal agencies for the purposes of mandatory reporting or investigations. Chambers Health may also be compelled to disclose your medical records pursuant to a valid court order.

Termination of Care. Chambers Health has the right to stoop treating you as a patient if you commit a substantial violation of Chambers Health's rules.

Chambers Health has the right to terminate its relationship with you immediately and without written warning if you create a threat to the safety of Chambers Health's staff or other patients.

Responsibilities as Your Provider

Quality Care and Patient Rights. Chambers Health has the responsibility to ensure that you are provided with quality care in environment that protects and promotes your rights as our patients. We are committed to providing culturally competent care and maintaining the highest standards of medical practice.

Malpractice Coverage. As a federally qualified health center, Chambers Health providers are covered under the Federal Tort Claims Act for malpractice protection when providing services within the scope of their employment.

Non-Retaliation. Chambers Health has the responsibility to ensure that no Chambers Health representative will punish, discriminate, or retaliate against you for filing a complaint, and Chambers Health will continue to provide you with services.

Coordination of Care. Chambers Health has the responsibility to coordinate your care with other healthcare providers when referrals or specialized services are needed, including providing necessary medical records and communication to ensure continuity of care.

Emergency Preparedness. Chambers Health has the responsibility to maintain emergency protocols and ensure staff are trained to handle medical emergencies that may occur on our premises.

For questions about this document or your rights and responsibilities, please contact:

Chambers Health Administration at 409-267-4126.

For medical emergencies, call 911 or go to your nearest emergency room. For after-hours clinical advice, call 281-576-0670 and press option 2 for the nurse advice line.

Chambers Health
Chambers County Public Hospital District No.1

PATIENT INFORMATION

INTERPRETATION SERVICES AVAILABLE

You have the right to an interpreter at no cost to you. Ask at the front desk.

Arabic	لك الحق في الحصول على مترجم فوري بدون تحمل أي رسوم من تجاهك. اسأل في مكتب الاستقبال.
Armenian	Դուք իրավունք ունեք անվճար թարգմանչի ծառայություն ստանալ: Հարցրեք գրանցման սեղանի մոտ:
Cambodian	លោកអ្នកមានសិទ្ធិទទួលបានអ្នកបកប្រែដោយឥតគិតថ្លៃ។ សូមសាកសួរនៅតុទទួលភ្ញៀវ។
Cantonese	您有權免費獲得一位口譯人員。請在前臺諮詢。
Farsi	شما این حق را دارید که بطور رایگان از خدمات یک مترجم استفاده کنید. در مورد این خدمات از کارکنان جلوی دفتر یا پشت پیشخوان جویا شوید.
Hindi	आपको निःशुल्क दुभाषिया प्राप्त करने का अधिकार है। फ्रंट डेस्क पर पूछताछ करें।
Hmong	Koj muaj cai tau txais ib tug kws txhais lus pub dawb. Nug ntawm lub rooj ua haujlwm nyob sab ntawm xub thawj.
Japanese	あなたには無料で通訳者のサービスを受ける権利があります。フロントデスクにお尋ねください。
Korean	당신은 통역사를 무상으로 이용할 권리가 있습니다. 프론트 데스크에 문의하세요.
Lao	ທ່ານມີສິດມີວ່າມຕປພາສາໂດຍບ່ຕ້ຍຄ່າ. ຖາມຢູ່ໂຕະຕ້ອນຮັບ.
Mandarin	你有权利免费获得翻译服务。请问前台。
Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਬਿਨਾਂ ਕਿਸੇ ਖ਼ਰਚ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲੈਣ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇਸ ਬਾਰੇ ਫਰੰਟ ਡੈਸਕ ਤੋਂ ਪੁੱਛੋ।
Russian	Вы имеете право на получение бесплатных услуг переводчика. Спросите на стойке регистрации.
Samoan	E iai lau aiia tatau mo se fa'amatalaupu e leai se totogi. Fesisli i le tagata oi le laulau i luma.
Spanish	Usted tiene el derecho a un intérprete sin costo alguno para usted. Pregunte en la recepción.
Tagalog	Mayroon kang karapatan sa isang tagapagsalin nang walang bayad. Magtanong sa front desk.
Thai	คุณมีสิทธิเป็นล่ามได้โดยที่คุณไม่ต้องมีค่าใช้จ่าย สอบถามได้ที่แผนกต้อนรับ
Vietnamese	Quý vị có quyền yêu cầu một thông dịch viên miễn phí. Xin hỏi ban tiếp tân.

**Translation services are also available in other languages, free of charge.
If another language is needed, please inquire at the front desk.

Updated 12.9.16