



**THE FORT WORTH NORTHSIDE COMMUNITY HEALTH CENTER, INC.
DBA/ Albert Galvan Health Clinic**

PATIENT REGISTRATION FORM

PATIENT NAME: _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

ADDRESS: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

HOME PHONE: _____ EMAIL ADDRESS: _____

SEX: () MALE () FEMALE BIRTHDATE: _____ SSN: _____

LANGUAGE: () ENGLISH () SPANISH () OTHER: _____ EDUCATION YRS: _____

RACE: () CAUCACIAN () HISPANIC () AFRICAN-AMERICAN () OTHER _____

STATUS: _____ MILITARY
() SINGLE () MARRIED () SEPARATED () DIVORCED () WIDOWED () VETERAN

EMPLOYMENT:
() FULL-TIME () PART-TIME () UNEMPLOYED () SELF-EMPLOYED () STUDENT

EMPLOYER NAME: _____ EMPLOYER PHONE #: _____

EMPLOYER ADDRESS: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

EMERGENCY CONTACT: _____ PHONE #: _____

() PRIVATE INSURANCE () MEDICAID () MEDICARE () SELP PAY () OTHER: _____

SPOUSE OR RESPONSIBLE PARTY

NAME: _____ HOME PHONE: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)

FAMILY FINANCE

FAMILY INCOME: \$ _____ () WEEKLY () BI-WEEKLY () MONTHLY () YEARLY

HOW MANY IN HOUSEHOLD: _____ HOW MANY MINOR CHILDREN: _____

PATIENT SIGNATURE: _____ DATE: _____



**THE FORT WORTH NORTHSIDE COMMUNITY HEALTH CENTER, INC.
DBA/ Albert Galvan Health Clinic**

PATIENT & CENTER RIGHTS & RESPONSIBILITIES

Welcome to Albert Galvan Health Clinic. Our goal is to provide quality health care to qualified persons in this community regardless of their ability to pay. If the Center is enrolling new patients, you may be eligible to become our patient. 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 any questions you might have.

Human Rights:

1. You have the right to be treated with respect and dignity regardless of race, religion, sex, national origin, sexual orientation, political affiliation or ability to pay for services.

Payment for Services:

2. You are responsible for giving us accurate information about your present financial status and any changes in your financial status. We need this information to decide how much to charge you and/or so we can bill private insurance, Medicaid, Medicare or other benefits for which you may be eligible for. If your income is less than the federal poverty guidelines you will be charged a discounted fee.
3. You have a right to receive explanations of our bill. You must 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 us know so we can provide care for you now and work out a payment plan.
4. Federal law prohibits us from denying you primary health care services which are medically necessary, solely because you cannot pay for these services.

Privacy:

5. You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private, only legally authorized persons may see your medical records unless you request it in writing for us to show them to someone else. A complete discussion of your privacy rights is attached as "*Notice of Client Privacy Rights*". By signing this document you are indicating that you have received this Notice. The Notice details the various rights granted to you by the Health Insurance Portability and Accountability Act.

Health Care:

6. You are responsible for providing us complete and current information about your health or illness so that we the clinic
7. can give you proper healthcare. You have the right and are encouraged to participate in decisions about your treatment.
8. 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 information about your health or illness, treatment plan (including risk) and expected outcome (if known) and information regarding Advance Directives. If you do not wish to receive this information or it is not medically advisable to share that information with you, we will provide it to a legally authorized person.
9. You are responsible for appropriate use of our services, which includes following our staff's instructions, making and keeping scheduled appointments and requesting a "walk in" appointment only when you are ill. We may not be able to see you unless you have an appointment. If you cannot follow the staff's instructions please tell us so we can help you.
10. If you are an adult, you have a right to refuse treatment to the extent permitted by law and to be informed of
11. the risks or refusing such care. You are responsible for the outcome of refusing treatment.
12. You have the right to health care and treatment that is reasonable for your condition and within our capability. You have the right to be transferred or referred to another facility for services that we cannot provide. But we do not pay for services that you get somewhere else. The Center is not an emergency care facility.
13. If you are in pain, you have the right to receive an appropriate assessment and management as necessary.



Center Rules:

14. You have the right to receive information on how to appropriately use the Center. You are responsible for using the Center's services in an appropriate manner, if you have questions please ask.
15. You are responsible for the supervision of children you bring with you to the Center. You are responsible for their safety and the protection of clients and our property.
16. You have the 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 asked to meet with the Executive Director or designee to determine the reason for your missed appointments and whether you can continue as a patient of the Center.

Complaints:

17. If you are not satisfied with our services, please let us know. We want suggestions so we can improve our services. We will tell you how to file a complaint; if you are not satisfied with how we handle your complaint you may protest to the Board of Directors.
18. If you make a complaint we will not punish you for filing a complaint and we will continue to provide services.

Termination:

19. If we decide that we must stop treating you as a patient, you have a right to advance notice that explains the reason for the decision. You will be given 30 days to find other health care services. We can decide to stop treating you immediately and without notice if you have created a threat to the safety of the staff and/or other clients. You have a right to receive a copy of the Center's termination of the Patient and Center Relationship policy.
20. Reasons for which we may stop seeing you include but not limited to:
 - 1) Failure to obey our rules, such as keeping scheduled appointments.
 - 2) Intentional failure to report accurate financial status.
 - 3) Intentional failure to report accurate information regarding your health or illness.
 - 4) Intentional failure to follow the health care program, such instructions as taking medications,
 - 5) Personal health practices or follow up appointments as recommended by your provider.
 - 6) Creating a threat to the safety of the staff and/or other clients.
21. If we have given you notice of termination of the patient and Center Relationship, you have the right to appeal decision with the Board of Directors. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

Acknowledgement of Receipt of Notice of Client Privacy Rights

22. I hereby acknowledge that I have received a copy of the *Notice of Client Privacy Rights*.

Print Name

Signature

Date



CONSENT TO TREATMENT: Each patient of the FWNCHC is treated pursuant to orders of his/her attending practitioner. I give my consent to my attending practitioner or his/her designees to perform or administer all tests and/or treatment which in the judgment of such practitioners are advisable during my visit to FWNCHC.

I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid FWNCHC may perform tests, with or without my consent on my blood or other bodily fluid to determine the presence of any contagious disease, including HIV. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of the clinic FWNCHC. I understand the results of tests done under these circumstances are confidential and do not become a part of my medical record.

CONSENT TO TREATMENT OF A MINOR: I hereby authorize the personnel of FWNCHC to render medical or surgical treatment to my dependent minor. This permit is valid for one year of the date of the signature.

RELEASE OF INFORMATION: I authorize FWNCHC to release/obtain information contained in my financial aid medical records, including diagnosis and test results to/from

1. any of my treating practitioners
2. my insurance company, health plan, its representative, its agents or independent contractors
3. any person or entity that is responsible for paying or processing for payment any portion of my medical treatment bill
4. to an person or entity affiliated with FWNCHC for the purpose of administration, billing, collecting, quality assessment or risk management
5. to any hospital, nursing home, home health agency or to any healthcare institution to which I am transferred.

I understand this consent applies to **all records** created in the course of my treatment and related to such while at FWNCHC. I release and agree to hold harmless FWNCHC and its agents, representatives and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand FWNCHC cannot be responsible for use or re-disclosure of information by third parties.

FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS: In consideration for the services to be rendered to me, I agree to pay for those services. I agree to assign to FWNCHC and any practitioner providing care/treatment to me the benefits under my insurance policies, prepaid health care plan or any other reimbursement source. I acknowledge that any balance not covered or paid by such policy or plan is my legal responsibility.

THIS IS A LEGAL CONSENT AND ASSIGNMENT OF BENEFITS FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING. A photo static copy of this consent form shall be valid and may be used and relied upon with the same effect as the signed original.

PATIENT OR LEGALLY AUTHORIZED PERSON SIGNATURE

DATE

PRINT NAME & RELATIONSHIP TO PATIENT IF OTHER THAN PATIENT

WITNESS