

PATIENT REGISTRATION

Name _____ Date of Birth _____

Street _____ Apt. _____ City _____ State _____ Zip Code _____ County _____

Phone _____ Email address: _____

Preferred method of contact: Call Text Email Patient Portal

Emergency Contact _____ Phone _____ Relationship _____

Social Security # or ITIN #: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African-Amer. <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unreported/Refused Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unreported/Refused	Are you? U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No U.S. Resident <input type="checkbox"/> Yes <input type="checkbox"/> No Language Spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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How did you find out about Christ Clinic? <input type="checkbox"/> Word of Mouth (family/friend/coworker) <input type="checkbox"/> Internet Search/Social Media <input type="checkbox"/> Hospital _____ <input type="checkbox"/> Church <input type="checkbox"/> Employer <input type="checkbox"/> Other _____	Referred By: <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Attack Poverty <input type="checkbox"/> Ballard House <input type="checkbox"/> Clothed by Faith <input type="checkbox"/> Compassion Katy <input type="checkbox"/> Hope Impacts <input type="checkbox"/> Katy Christian Ministries </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Katy Cares <input type="checkbox"/> Methodist Hospital <input type="checkbox"/> Memorial Hermann <input type="checkbox"/> Texas Children's <input type="checkbox"/> UTMB <input type="checkbox"/> YMCA </td> </tr> </table>	<input type="checkbox"/> Attack Poverty <input type="checkbox"/> Ballard House <input type="checkbox"/> Clothed by Faith <input type="checkbox"/> Compassion Katy <input type="checkbox"/> Hope Impacts <input type="checkbox"/> Katy Christian Ministries	<input type="checkbox"/> Katy Cares <input type="checkbox"/> Methodist Hospital <input type="checkbox"/> Memorial Hermann <input type="checkbox"/> Texas Children's <input type="checkbox"/> UTMB <input type="checkbox"/> YMCA
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If Christ Clinic were not available for you today, would you have to go to the ER for treatment? Yes No

MONTHLY HOUSEHOLD INCOME AND HOUSING INFORMATION		
Total Dollars Received Each Month for Entire Household		Household Size:
Wages/Salary \$ _____	Social Security \$ _____	Total # of ADULTS living in the household _____
Unemployment \$ _____	Child Support \$ _____	
Workmen's Comp \$ _____	Other \$ _____	Total # of CHILDREN under 18 years in the household _____
Disability \$ _____	Total Monthly Income \$ _____	

PATIENT COVERAGE INFORMATION (Do you have or receive?)	
Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No CHIP: <input type="checkbox"/> Yes <input type="checkbox"/> No Gold Card: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of insurance company _____

_____ Patient /Guardian Signature
_____ Patient/Guardian Printed Name
_____ Date

CONSENT FOR CHARITY CARE

I, _____, acknowledge that volunteer health care providers, the physicians and staff of Christ Clinic are immune from any civil liability for any act or omission resulting in death, damage or injury as the volunteer acts are in good faith and in the scope of his/her duties within the organization in providing the health care services.

PATIENT /GUARDIAN SIGNATURE

DATE

ACKNOWLEDGEMENTS

I have received and reviewed the following from Christ Clinic (please check):

- Patient Rights & Responsibilities
- Notice of Privacy Rights

By signing this, I am fully aware of both documents and agree to the information provided in each.

PATIENT/GUARDIAN SIGNATURE

DATE

DESIGNATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Some patients prefer that other individuals, especially family members, be allowed to access their medical information. In accordance with Federal government privacy rules, a written release is required to allow another person access to your medical records. This release grants permission to the individual(s) listed below to: make or confirm appointments, have access to x-rays and laboratory findings, pick up medication, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact.

- I do NOT give permission for anyone else to be contacted other than myself.
- I give permission to contact the following people:

Name	Telephone	Relation to Patient	Please mark your selection	
			pick up medications	
			make appointments	
			receive medical information	
			pick up medications	
			make appointments	
			receive medical information	



Answering Machine Messages

There may be times when our office is not able to reach you by telephone. With your permission, we would like to be able to leave messages on your home answering machine or voice mail.

Home voice mail? Yes No Cell phone voice mail? Yes No

Messages will not be left on answering machines or voice mail if the recorded greeting does not include confirmation of your name or phone number.

PATIENT/GUARDIAN SIGNATURE

DATE



Christ Clinic
25722 Kingsland Blvd. Ste. 111
Katy, TX 77494
(281) 391-0190
www.christclinickaty.org

Improving Quality of Life Through Affordable Primary Care

Purpose of Consent: By signing this form, you are consenting to allow Christ Clinic to use your photograph via various marketing materials, including web site, email, print, and other marketing and materials. If at any time, you would like to remove your photograph from future use, you may do so by contacting Christ Clinic.

CONSENT TO RELEASE

I hereby authorize Christ Clinic to use my photograph and any information contained within its public relations efforts. I understand and approve the disclosure of my photograph to the media and other individuals and entities that may be involved in the public relations efforts of Christ Clinic.

I understand that I am providing my photograph to Christ Clinic and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release Christ Clinic from any and all claims for damages of any kind based on the use of my photograph. By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Patient Testimonial.

Signature

Date

Print Name

Please provide your contact information:

Address

Phone

Email

Thank you!



Patient Authorization for Greater Houston Healthconnect

_____ [NAME OF PARTICIPANT] participates in Healthconnect, a non-profit organization that provides a secured electronic network for Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payers of health claims such as health insurers to share your protected health information. ("PHI") A list of current Healthconnect participants is available at www.ghhconnect.org. When you join Healthconnect, your doctors can electronically search all Healthconnect participants for your PHI and use it while treating you. Healthconnect does not change who gets to see your information—it allows your information to be shared in a new way. All Healthconnect participants must protect your privacy in accordance with state and federal laws.

Your treatment and eligibility for benefits will not be affected in any way should you choose not to join Healthconnect.

By signing this Authorization, you agree that Healthconnect and its current and future participants may use and disclose your protected health information electronically through Healthconnect **for the limited purposes of treatment, payment and health care operations**. You understand that Healthconnect may connect to other health information exchanges in Texas and across the country that also must protect your privacy in accordance with state and federal laws, and you authorize Healthconnect to share your information with those exchanges for the same limited purposes.

This authorization remains in effect unless and until you revoke it. You can revoke this authorization at any time by giving written notice to any healthcare provider who participates in Healthconnect. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect.

Patient Name: _____

Signature of Authorized Person: _____ Date: _____

Name (if different from Patient): _____ Relationship to Patient: _____

Initial here if you do NOT want your providers to see your records through Healthconnect. _____



PATIENT HEALTH HISTORY

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Please complete all sections and add any notes you think are important.

ALL INFORMATION PROVIDED WILL BE KEPT STRICTLY CONFIDENTIAL

Patient Name: _____ Date of Birth: _____

Allergies: Please list all medication allergies No allergies

Medication:	Type of Reaction

Current Medications: Please list ALL medications you are currently taking

I do not take any medications

Medication Name and Dose	How many times/day?	Medication Reason

Current Medical Problems: Please check any medical problems that you currently have or have had in the past

<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anxiety	<input type="checkbox"/> DVT	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> COPD	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Liver Disease	

Family History: Please check any conditions experienced by members of your family

<input type="checkbox"/> Anxiety	Mother	Father	Sibling	Grandparent
<input type="checkbox"/> Depression	Mother	Father	Sibling	Grandparent
<input type="checkbox"/> Diabetes	Mother	Father	Sibling	Grandparent
<input type="checkbox"/> Heart Disease	Mother	Father	Sibling	Grandparent
<input type="checkbox"/> Stroke	Mother	Father	Sibling	Grandparent
<input type="checkbox"/> High Blood Pressure	Mother	Father	Sibling	Grandparent
<input type="checkbox"/> High Cholesterol	Mother	Father	Sibling	Grandparent
<input type="checkbox"/> Cancer; Type _____	Mother	Father	Sibling	Grandparent

Surgical History: Please list all surgical operations you have had

Year	Operation

Social History: Please answer all questions

Cigarette Smoking:	<input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current # of cigarettes per day: # of years:
Chewing Tobacco:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic cigarettes:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol Use:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of drinks per week:
Any other drugs or substances:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type:
Occupation:	
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Highest Education Level Achieved:	
Do you visit the dentist at least once a year for cleanings or screenings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an advanced directive (plan for end of life health care)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Would you like info about how to make one? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any communication needs that we need to be aware of?	<input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Cognitive If yes, please explain: _____
How often do you see or talk to people that you care about and feel close to?	<input type="checkbox"/> Less than once a week <input type="checkbox"/> 1 or 2 times a week <input type="checkbox"/> 3 to 5 times a week <input type="checkbox"/> 5 or more times a week

For Women ONLY

Gynecologic History

Date of last pap smear:	
History of abnormal pap smear?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date _____
Current method of birth control:	
If postmenopausal, age of menopause:	







Name _____ DOB _____

Zip code _____

We care about you and your family. Your answers can help us know you better and build new partnerships in our community to help meet all of our patients' needs. You can skip questions or stop at any time. Whether you do this survey or not, we will continue to provide you services.

CHECK ALL BOXES THAT APPLY TO YOU AND YOUR FAMILY.

	In the past year, have you worried that you would run out of food or you worried you wouldn't have enough money to buy more food?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you miss medical appointments because you have no way to get there or because it is hard to get there?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you feel physically or emotionally unsafe where you currently live?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you need help reading or understanding medical forms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



CHRIST CLINIC – RIGHTS & RESPONSIBILITIES

Welcome as a patient to Christ Clinic. Our mission is to provide you and your family with not only quality healthcare, but care and compassion. In order to fulfill our mission, the following rights and responsibilities have been established to assure our purpose can be met.

You have the right:

- To be treated with the utmost respect and dignity no matter their ethnicity, gender, religion or income.
- To health care and treatment that is reasonable for your condition and within our capability.
- To make decisions about your health care while discussing it with your provider.
- To refuse treatment, care and services allowed by the law while understanding the risks that could occur with this refusal.
- To personal privacy and confidentiality during interviews, examinations and treatment. Please review the "Notice of Privacy Rights" for more information about this right.
- To access your medical records.
- To speak to someone on the management team if you have a complaint.

You are responsible:

- To treat the Christ Clinic staff with the same respect and dignity as given. Christ Clinic's Executive Director and/or Clinic Director reserve the right to refuse service to anyone acting in an inappropriate manner.
- To provide updated contact information (phone, address, and e-mail) for all provider/patient communication
- To comply with medical recommendations. Failure to comply with a medical recommendation or medical orders will result in your release from the care of your provider and from Christ Clinic. You will be deemed noncompliant if you fail to adhere to orders regarding medication, lab work and/or follow-up appointments.
- **To keep and be on time** for your appointment(s). Anyone arriving 5 minutes or later after their scheduled appointment will be required to reschedule for a later date. If you are not able to make your appointment, please call as soon as possible so we accommodate others.
- To provide Christ Clinic with accurate information about your financial status and resources as well as any changes that may occur. This includes having Medicaid, Medicare, CHIP, Gold Card, or another form of insurance.
- **Provide proof of household income at least once a year or when required.** For example, 2 months of recent pay stubs and/or a copy of your taxes from the most recent year are required. To access third-party services (for example, drug assistance and specialty services), a copy of the recent year's tax return is required. If you cannot provide either option, your in-person visit will start at \$ 50.00 or telemedicine at \$ 35.00 - not including additional tests, lab orders, or prescriptions.
- We accept cash, credit, and debit. *
- To respect the privacy of other patients while at the clinic. Please keep cell phones off. Due to COVID-19 guidelines, we are only allowing the patient with an appointment to come in the waiting area.
- To supervise your children at all times. Unattended minors are not allowed in the waiting room. You are responsible for their safety and protection while visiting Christ Clinic.

**With the use of a Debit/Credit card, \$1.00 fee will be added for the service.*

Termination:

If we decide that the provider – patient relationship has come to an end, you have a right to advance notice that explains the reason for the decision. You will be given 30 days to find another health care provider. If a threat to Christ Clinic or its staff is made, this decision can be made effective immediately. Reasons for which we may end the provider – patient relationship includes but not limited to:

1. Failure to follow the responsibilities listed above such as keeping scheduled appointments.
2. Intentional failure to report accurate financial and insurance status.
3. Intentional failure to provide accurate information about your health or illness.
4. Intentional failure to follow the instructions given by your provider regarding medications, follow-up appointments, health practices.
5. Making a threat against Christ Clinic staff/volunteers or patients.



CHRIST CLINIC – NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.

The *Health Insurance Portability & Accountability Act of 1996* (“HIPAA”) is a federal program that requires all medical records and other individually identifiable protected health information (PHI) used or disclosed by us in any form, whether electronically, on paper, or orally, to be kept confidential. You have rights to understand and control how your health information is used. We are required to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to PHI

We may use and disclose your medical records without authorization only for the following purposes:

- **Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers. We may disclose your information to doctors, nurses and other health care personnel who are involved in your care.
- **Health Care Operations:** for appointment and patient recall reminders. Also includes the business aspects of running our practice, such as conducting clinic improvement activities, employee training, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.
- **When Required To Do So By Federal, State Or Local Law** This may include the following: 1) business associates; 2) to avert a serious threat to health or safety; 3) public health risks; 4) health oversight activities; 5) judicial and administrative procedures; 6) specific government functions; 7) research and organ donation; 8) coroners and funeral directors; and 9) communications with caregivers and relatives.
- **Any other uses and disclosures will be made only with your written authorization.** You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the management team.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. Written request is needed.
- The right to amend your protected health information.
- The right to receive a list of how your protected health information was disclosed other than treatment, payment or health care operations, as listed above.

You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint. If you have any questions or to make a request regarding the rights described above, please contact:

Christ Clinic
Management Team
25722 Kingsland Blvd Ste:111
(281) 391-0190

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 or Toll Free: 1-877-696-6775