Patient Registration Form

accesshealth™

NCQA Patient-Centered Medical Home Recognized Practice | FQHC | United Way of Greater Houston

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Family Physician or Pediatrician:	Date of Birth:	Sex: ❑ Male ❑ Female	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor.

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Spanish ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Vietnamese ☐ Mandarin/Cantonese ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to AccessHealth's payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to AccessHealth all money to which I am entitled for medical expenses related to the services performed from time to time by AccessHealth, but not to exceed my indebtedness to AccessHealth. I authorize AccessHealth to release any medical information to my insurance carrier or third party payer to facilitate processing of my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. I choose to receive communications from AccessHealth by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to AccessHealth. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____ **Date:** _____

Household Information

Total Monthly Household Gross Income: **$** _____ **Total People in Household:** _____

Student: _____Full-Time ____Part-Time _____Not in School

Employment Status: _____Full-Time ____Part-Time _____Not Employed

Agriculture Status: _____ Migrant Worker _____ Seasonal Worker _____ Not an Agriculture Worker

Are you a US Military Veteran: _____ Yes _____ No

Housing Status: *(Please indicate your living situation)*

_____ Both Parents _____ Spouse _____ Father _____ Mother
_____ Doubling Up _____ Homeless Shelter _____ Not Homeless _____ Unknown
_____ Other _____ Street _____ Transitional

Sexual Orientation / Gender Identity

Do you think of yourself as:

_____ Straight or heterosexual _____ Lesbian, gay or homosexual
_____ Bisexual _____ Don't Know Something else, please describe _____

What is your current gender identity?*(mark all that apply)*

_____Male _____Female _____Transgender male / Trans-man / Female-to-male
_____Transgender female / Trans-woman / Male-to-female _____Genderqueer, neither exclusively male nor female
_____Decline to answer Additional gender category/ other (please specify): _____

EACH MEMBER OF YOUR HOUSEHOLD WHO WILL BE A PATIENT OF ACCESSHEALTH MUST COMPLETE THIS FORM.

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

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

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

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

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

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

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

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

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

Texas Vaccines for Children Program
Patient Eligibility Screening Record

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

1. Child's Name: _____ _____ _____
Last Name First Name MI

2. Child's Date of Birth: ____ / ____ / _____

3. Parent, Guardian, or Individual of Record: _____ _____ _____
Last Name First Name MI

4. Primary Provider's Name: _____ _____ _____
Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. *If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.*

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

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

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

**** Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC Program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.*

Texas Vaccines for Children Program
Patient Eligibility Screening Record
(Continued)

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

Medicaid:

Medicaid Number: _____

Date of Eligibility: _____

CHIP:

CHIP Number: _____

Group Number: _____

Date of Eligibility: _____

Private Insurance:

Name of Insurer: _____

Insurance Name: _____

Insurer Contact Number: _____

Policy or Subscriber Number: _____

Welcome to Your Medical Home

MAKE EACH DOCTOR'S VISIT WORK FOR YOU!

Before your visit

- Write your own questions and worries. Do not worry if it's a long list.
- If you see specialist, ask them to send their report to your primary provider here at AccessHealth.
- Confirm that your registration with AccessHealth is up to date.

On the day of your visit

- Provide us with your complete medical history and information from any another medical provider.
- Put all your medicines in a bag and bring them with you to your doctor's visit.
- Bring your Medicare, Medicaid, or other insurance card. Bring your list of questions.
- Please ask for help, ask a friend or family member to join you.

During your visit

- Relax! Ask questions! Take Notes. Tell us when you don't understand. Remember we want the very best for you.
- Ask us to tell you the values of your blood pressure, weight, and lab tests. Keep a record of these.
- Ask us when you should schedule your next visit.

After your visit

- Keep your medical information in one place-ready for the next visit.

Things that you can do for your self

- Learn as much as you can about how to care for your illness. The more that you know, the better will be your health.
- Some health problems such as diabetes require you to change how you are eating and living. Talk with your doctor, family and friends as to how you can make these changes. Start enjoying the benefits of better health now.
- Make sure that you understand how to take your medicine. If you do not understand how to take them, ask us for help.
- Don't stop taking prescription medicine without first talking with your healthcare provider.

Call 24 Hours a Day, 7 Days a week

RICHMOND	STAFFORD	MISSOURI CITY	BROOKSHIRE	EAST FORT BEND
281-342-4530	**281-342-4530**	**281-342-4530**	**281-822-4235**	**281-342-4530**
400 Austin Street	10435 Greenbough Dr, Ste 300	307 Texas Parkway, Ste 100	531 FM 359 S	7707 Highway 6 South
Richmond, TX 77469	Stafford, TX 77477	Missouri City, TX 77489	Brookshire, TX 77423	Missouri City, TX 77459

When to Choose the Hospital/Emergency Room or AccessHealth, Your Medical Home

We are fortunate in our community to have access to 24-hour Emergency Room care. Of course, no one can time an illness or injury to occur during the hours of a doctor's office or clinic. But many acute illnesses, such as colds, flu, sprains, strains, minor infections, minor cuts and bruises, skin rashes, common diarrhea, lower back pain, mild vaginal infections, and irregular periods do not require an Emergency Room visit. Such ailments usually resolve on their own within a short period of time. If they require medical treatment, they should always be addressed at AccessHealth, your Medical Home. Generally, you should not go to the Emergency Room for medication refills, or medical problems that are chronic in nature, unless you experience sudden worsening of your condition. Always choose your Medical Home for check-ups, shots, and help with long term conditions.

So, when **should** one seek care at the Emergency Room? There are certain symptoms that should prompt an ER visit even during operating hours of AccessHealth. These include:

1. Severe chest pain
2. Vomiting Blood
3. Sudden loss of consciousness or change in mental status (acting strange)
4. Sudden weakness of body parts
5. Severe difficulty breathing
6. Overdose of medicine or ingestion of toxic substance. Call Poison Control at 1.800.222.1222
7. Severe burns or inhalation of smoke
8. Uncontrollable bleeding that will not stop
9. Attempted suicide
10. Emergency labor/ childbirth
11. Severe trauma (injury)
12. Sudden severe abdominal pain
13. Sudden severe headache or sudden loss of vision
14. New seizure (convulsion)

Sometimes it may not be clear when an illness is serious enough to use the Emergency Room. Children and older persons, or patients with underlying illness may need medical attention sooner than a young adult or otherwise healthy person. If you are not sure what to do and it is during AccessHealth office hours, you should call or come into the office. ***After hours you may call the office number*** and speak with the physician on-call about your illness.

It is important that you get proper care, and in a true emergency that means calling 911 or going to the Emergency Room; otherwise it means care at AccessHealth, your Medical Home. If you go to the Emergency Room, please schedule an appointment with AccessHealth within 10 days of your discharge.

Call 24 Hours A Day, 7 Days A Week

RICHMOND CENTER: 400 Austin St., Richmond, TX 77469
(281) 342-4530

ADULT CARE:
Monday – Friday: 7:00AM - 7:00PM; Saturday: 8:00AM - 12:00PM

PEDIATRIC CARE:
Monday, Tuesday, Thursday, Friday 7:00AM - 5:00PM; Wednesday: 7:30AM - 5:30PM; 2nd and 4th Saturday: 8:00AM - 12:00PM

STAFFORD CENTER: 10435 Greenbough Dr., Stafford, TX 77477
(281)261-0182

PEDIATRIC CARE: Monday – Friday: 7:00AM - 7:00PM; Saturday: 8:00AM - 12:00PM

DENTAL: Monday - Friday: 7:00AM - 7:00PM; Saturday: 8:00AM – 12:00PM

MISSOURI CITY CENTER: 307 Texas Parkway, Missouri City, TX 77489
(281) 969-1800

ADULT CARE:
Monday, Tuesday & Thursday: 8:00AM - 5:00PM;
Wednesday: 9:00AM - 6:00PM; Friday: 7:00AM - 4:00PM

PEDIATRIC CARE:
Tuesday: 7:00AM – 7:00PM; Wednesday – Friday: 8:00AM – 5:00PM

EAST FORT BEND CENTER: 7707 Highway 6 South, Missouri City, TX 77459
(281) 342-4530

Monday – Friday: 8:00AM – 12:00PM

BROOKSHIRE CENTER: 533 FM 359 S., Brookshire, TX 77423 – (281) 822-4235

Monday – Thursday: 7:30AM – 5:30PM; Friday: 8:00AM – 5:00PM