PATIENT PORTAL

ACCESS YOUR MEDICAL RECORDS ONLINE AT www.chambershealth.org

CLICK ON "Clinic Patient Portal"

To enroll, please provide your email address. We will send you a link with your login information.

NAME:____

EMAIL ADDRESS:____

healow

Access your health records through the healow mobile app

DOWNLOAD THE FREE HEALOW APP

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Find us using our unique practice code on the healow app

BDJECA

VIEW LAB RESULTS

SEND AND RECEIVE SECURE MESSAGES

REQUEST APPOINTMENTS

Chambers Community Health Centers, Inc.

"What You Need - Where You Are"

PATIENT INFORMATION / CONSENT FORM

Patient Name: ____ **Date of Birth**: ____________
Last, First Middle Initial

Mailing Address: ____
City State Zip Code

Home#: ____________________ **Cell #**: ____________________ **Work #**: ____________________

Email: ________________________________ **Social Security #**:________--________--________

Responsible Party: ____________________ **Relationship**: ____________ **Phone#**:____________

Emergency Contact: ____________________ **Relationship**: ____________ **Phone #**: ____________

Sex:
- ☐ Male
- ☐ Female
- ☐ Transgender

Sexual Orientation:
- ☐ Lesbian, Gay, or Homosexual
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Do not know
- ☐ Choose not to disclose
- ☐ Something else:____________

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

# of people in Household: ________

Household Income:
- ☐ Under $20,000
- ☐ $20,00-$40,000
- ☐ $40,00-$80,000
- ☐ Over $80,000

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Female to Male/Transgender Male
- ☐ Male to Female/Transgender Female
- ☐ Genderqueer, neither male nor female
- ☐ Choose not to disclose
- ☐ Other: Describe____________

Language:
- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other:________

Race: Check all that apply.
- ☐ White, Caucasian
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Unreported/Refused to Report

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused to Report

Disability:
- ☐ Yes
- ☐ No

Veteran:
- ☐ Yes
- ☐ No

Primary Insurance: ____________________ **ID #**____________________ **Group #**____________

Policy Holder's Name: ______________________________ **Policy Holder's DOB**: ____________

Secondary Insurance: ____________________ **ID #**____________________ **Group #**____________

Policy Holder's Name: ______________________________ **Policy Holder's DOB**: ____________

THE FOLLOWING CONSENTS REMAIN IN EFFECT UNTIL REVOKED IN WRITING

Authorization of Benefits to Provider: I understand that I am financially responsible for all charges incurred with Bayside Clinic and/or West Chambers Medical Center, herein after referred to as 'Health Center.' I hereby assign and relinquish my interest in and title to my insurance benefits to the Health Center for all medical services rendered.

Acknowledgement of Receipt of Notice of Privacy Practices (NOPP): I hereby acknowledge that I have received a 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) may not be received by the intended recipient. Should this occur, I release the Health Center from all liability.

Permit for Diagnosis and Treatment: I understand that presentation to the clinic is indicated by my condition or medical need. I voluntarily authorize and consent to the customary examinations, test, and procedures performed on patients in my condition and to routine medical treatment ordered by the Health Center's physician, physician's assistant, OR nurse practitioner.

PLEASE CIRCLE "YES" OR "NO" FOR THE FOLLOWING:		
I understand patient privacy laws apply to telehealth. I consent to receive services via **telehealth** appointments, when applicable.	**YES**	**NO**
I consent to join the secure health information exchange network, "**Greater Houston Health Connect**" (GHH), which electronically shares my protected health information with other participating providers and facilities.	**YES**	**NO**
I authorize the Health Center to take and/or use **photographs or electronic images** for the purpose of identity verification and/or my medical care.	**YES**	**NO**

______________________________ ____________________ **Date**_____ /______ /20_____
Signature of Patient or Authorized Representative **Relationship to Patient**

Chambers Community Health Centers, Inc.

PATIENT HISTORY

Date:

Name *(Last, First, M.I.)*:			**Date of Birth:**
Previous or Current PCP Name:		**Pharmacy Name:**	
Previous or Current PCP Phone #:		**Pharmacy Phone #:**	

MEDICAL HISTORY

Are your immunizations up to date? **Yes** **No** **(INCLUDE SHOT RECORD FOR AGES 17 AND UNDER)**

Please mark if you have, or have ever had, any of the following conditions or symptoms: **None** ☐

Acne / Skin Problems	Bladder Infection	Heart Disease	Thyroid Problems	Stomach / Intestinal Problems
Asthma / Lung Disease	Sexually Transmitted Disease	High Blood Pressure	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	Cancer	Diabetes	Anemia	Sleep Apnea

Please list other health conditions or concerns:

SOCIAL & BEHAVIORAL HISTORY

None ☐

Low Self-Esteem	Depression / Mood Swings	Housing Issues	Alcohol Abuse	Legal Trouble
Attempted Suicide	Family Stressors	Gang-Related Issues	Drug User	Physical / Emotional Abuse
Trouble Sleeping	Financial Problems	Fad Diets	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

None ☐

Age	Reason	Hospital

CURRENT MEDICATIONS

None ☐

Prescription / Vitamin / Supplement / Over-the-Counter Medication	Strength / Dose	Frequency Taken

ALLERGIES / DRUG INTOLERANCES

None ☐

Allergy / Intolerance	Reaction

FAMILY HISTORY

None ☐

Please mark if anyone in your family currently has, or has ever 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 years old)										
Thyroid Problems										
Tuberculosis										
Drug Abuse										
Alcohol Abuse										
Learning Problems										
Mental Illness										
Other:										

CHAMBERS COUNTY PUBLIC HOSPITAL DISTRICT #1
NOTICE OF PRIVACY PRACTICES
EFFECTIVE APRIL 14, 2003
Revised June 2013

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 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 Community Hospital, 200 Hospital Drive, P.O. Box 398, Anahuac, Texas 77514, (409) 267-3143
- Bayside Clinic, 621 South Ross Sterling, Anahuac, Texas 77514, (409) 267-4126
- West Chambers Medical Clinic, 9825 Eagle Drive, Baytown, Texas 77520, (281) 576-0670
- The Wellness Center at Bayside, 2202 South Main Street, Anahuac, Texas 77514, (409) 267-3700

Our Responsibilities:
We are required by law to maintain the privacy of your health information and provide you 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 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 either facility.
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 Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

We may also use and disclose health information: To business associates we have contracted with to perform the agreed upon service and billing for it; To remind you that you have an appointment for medical care; To assess your satisfaction with our services; To tell you about possible treatment alternatives; To tell you about health-related benefits or services; To contact you as part of fundraising efforts; To inform Funeral directors consistent with applicable law; For population based activities relating to improving health or reducing healthcare costs; and For conducting training programs or reviewing competence of healthcare professionals.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to; Food and Drug Administration, Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability, Correctional Institutions, Workers Compensation Agents, Organ and Tissue Donation Organizations, Military Command Authorities, Health Oversight Agencies, Funeral Directors, Coroners, and Medical Directors, National Security and Intelligence Agencies, Protective Services for the President and Others.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

- Inspect and Copy, Request an Amendment, Request an Accounting of Disclosures, Request Restrictions, Request Confidential Communications, and to Receive a Full Copy of This Notice.
- You may also print or view a copy of the Notice of Privacy Practices link at www.chambershealth.org.

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

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 surgery center 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. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*

If you have any questions about this notice, please contact the Facility Privacy Officer at (409) 267-3143.

Visit us at www.chambershealth.org