PATIENT REGISTRATION FORM / INFORMACION DE REGISTRO

PLEASE PRINT / FAVOR DE ESCRIBIR EN MOLDE

PATIENT / PACIENTE

LAST NAME / APELLIDO	FIRST NAME / PRIMER NOMBRE	MIDDLE NAME / APELLIDOS	☐ MALE / MASCULINO ☐ FEMALE / FEMENINA
BIRTHDATE / FECHA DE NACIMIENTO	SSN / NUMERO DE SEGURO SOCIAL	COUNTY / CONDADO	
MAILING ADDRESS / DIRECCIÓN DEL CORREO		APT NO / NUMERO DE APARTAMENTO	
ZIP / CODIGO POSTAL	CITY / CIUDAD	STATE / ESTADO	

PLEASE CHECK THE NUMBER WHERE WE MAY CONFIDENTIALLY CONTACT YOU AND/OR LEAVE A MESSAGE
PORFAVOR MARQUE EL NUMERO DE TELEFONO DONDE PUEDAMOS DEJAR UN MENSAJE CONFIDENCIAL.

☐ HOME PHONE / TELEFONO DE LA CASA	☐ CELL PHONE / TELEFONO DE CELULAR	☐ **OK to send text reminders / Esta bien de mensajes de texto**
EMAIL ADDRESS / DIRECION ELECTRONICO	LANGUAGE/ LENGUAJE: _____	MARITAL STATUS / ESTADO CIVIL: ☐ MARRIED / CASADO(A) ☐ SINGLE / SOLTERO(A) ☐ DIVORCED /SEPARATED / DIVORCIADO(A)/SEPARADO(A) ☐ WIDOWED / VIUDO(A)

ETHNICITY/ETHNICIDAD:
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO
☐ UNREPORTED/REFUSED TO REPORT

RACE/RAZA:
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ ASIAN
☐ BLACK OR AFRICAN AMERICAN
☐ WHITE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ UNREPORTED/REFUSED TO REPORT

CITIZENSHIP/CIUDADANO:
☐ US CITIZEN / CIUDADANO ☐ LEGAL PERMANENT RESIDENT / RESIDENTE LEGAL ☐ OTHER / OTRO

FAMILY SIZE AND INCOME AS NOTED ON PROOF OF INCOME DOCUMENT(S)/NUMERO EN FAMILIA Y PRUEBA DE INGRESO

FAMILY SIZE/NUMERO EN FAMILIA	YEARLY INCOME/INGRESO DEL AÑO	SIGNATURE/FIRMA	DATE/FECHA

LIST EVERYONE WHO LIVES IN YOUR HOME

LAST NAME / APELLIDO	FIRST NAME / PRIMER NOMBRE	RELATIONSHIP / RELACIÓN	AGE / EDAD

RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY

I hereby authorize Samaritan Health Ministries (SHM) to release any medical or other information needed to process all insurance claims. I agree that I am responsible for payments for services rendered. I am aware that failure to pay may result in termination of the patient/clinic relationship. A photocopy of this authorization shall be considered as valid as the original. This authorization will remain in effect until revoked by me in writing.
By signing this form, I am saying that I understand what is written above and that I voluntarily ask for and consent to treatment.

PATIENT OR AUTHORIZED SIGNATURE / FIRMA DE PACIENTE O AUTORIZADA

LA LIBERACION DE INFORMACION/RESPONSABILIDAD FINANCIERA

Con la presente autorizo a Samaritan Health Ministries (SHM) a dar información médica o otra información necesitada para procesar todos los reclamos de seguro. Estoy consiente que es mi responsabilidad el pago por servicios que recibo. Estoy consiente que el no pagar podría resultar en la terminación de mi relación con la clínica. Una fotocopia de esta autorización será considerada igual de válida como la original. Seguirá en efecto esta autorización hasta ser revocado por mí por escrito. Al firmar esta forma, estoy diciendo que entiendo lo que esta escrito arriba y yo voluntariamente y concientemente pido tratamiento medico.

DATE/FECHA

Samaritan Health Ministries

Consent for Treatment and Agreement to Privacy Practices

Patient Name:_____ Birthdate:_____

1. I understand that medical, dental, and other health-related services at Samaritan Health Ministries (SHM) are provided by licensed and certified health professionals, including: physicians, resident physicians, and dentists, as well as alternative health providers, including nurse practitioners, nurses, physician assistants, midwives, social workers, and psychologists. I understand that I have the right to request to see a physician rather than an alternative health provider.

2. I understand that services I receive at SHM may be provided by a volunteer who is providing medical care that is not administered for or in expectation of compensation. I further understand that Texas law imposes on the recovery of damages from such volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if: the volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization; the volunteer commits the act or omission in the course of providing health care services to the patient; the services provided are within the scope of the license of the volunteer; and before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges that the volunteer is providing care that is not administered for or in expectation of compensation; and the limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

3. As an SHM patient, I understand that I need to go to a hospital emergency room if I have a medical emergency.
4. If necessary in the course of my care, I consent for my SHM Provider to access my medication history, if available, from retail pharmacies.
5. I understand that SHM services are provided regardless of race, residence, religion, income, sex, age, national origin, color, sexual preference, or contraceptive preference.
6. I understand my records are confidential. **I have read and agreed to Samaritan Healthcare Ministries' Patient Privacy Practices which explain how my records will be handled.**

I understand the information above and I voluntarily request and consent to the services of this clinic (tests, treatments, procedures and other services as indicated) for myself or the minor I am accompanying. I understand that this consent is valid until revoked in writing.

Signature of patient or authorized adult:_____ Date: _____

Signature of interpreter, if any: _____

Printed name of authorized adult accompanying minor: _____

SAMARITAN HEALTH MINISTRIES

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

This document provides the authorization for the release of information as indicated below. Information about you cannot be released to others without your consent, except as authorized by law. Do not sign this release unless it is completed and in your best interests.

Patient: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone #: _____ Email: _____

People approved to receive medical information or who may pick up prescriptions:

Name: _____ Relationship: _____

Phone #: _____

Information to be Released:

[ ] Next appointment date [ ] Laboratory Reports [ ] X-ray Reports [ ] Medication

Name: _____ Relationship: _____

Phone #: _____

Information to be Released:

[ ] Next appointment date [ ] Laboratory Reports [ ] X-ray Reports [ ] Medication

Name: _____ Relationship: _____

Phone #: _____

Information to be Released:

[ ] Next appointment date [ ] Laboratory Reports [ ] X-ray Reports [ ] Medication

Signature of Patient _____ Date: _____

Witness: _____

Patient Rights and Responsibilities

Patient Responsibilities

Effective healthcare requires patient involvement and responsibility. To ensure the best possible treatment and results, we ask that you:

- **Provide as much information as possible** about your health and medical history. Tell us all you know about your present illness, health history, medications you are taking (including over the counter and herbal medications), medication allergies and anything else about your health that would help us treat you.

- **Communicate with us.** Tell us if you do not understand what our staff is saying to you or if you do not understand your treatment plan. If you choose not to follow the treatment plan recommended, let your provider know of your decision.

- **Let us know at least 24 hours in advance if you need to cancel an appointment** so we may offer your appointment time to another patient.

- **Accept responsibility for your actions** if you decline treatment or do not follow your provider's instructions.

- **Ask your provider or medical assistant** when and how you will receive the results of tests and procedures.

- **Report unexpected changes in your condition** to your provider.
- **Follow the clinic's rules and regulations.**

- **Act in a manner that is respectful** of other patients, our staff, our volunteers, other patients, and clinic property. Threats, swearing and abusive language will not be tolerated.

- **Respect the privacy of other patients** who are being seen in our practices, which includes not taking pictures.

- **Meet your financial obligatio**n to Samaritan Health Ministries.

PHOTOGRAPHY/VIDEO ACKNOWLEDGEMENT

At Samaritan Health Ministries, photos and videos may be taken periodically to document day to day activities, special occasions, and patient milestones. Photos and videos taken are the property of Samaritan Health Ministries and may be used for the website, social media pages, newsletters, and/or any other promotional materials for Samaritan Health Ministries.

By consenting to have your photo/video taken by staff, volunteers, or other individuals while participating in activities at the clinic, you are giving consent for the pictures to be used by Samaritan Health Ministries. You have the right to decline having your picture taken or participating in any video at any time.

☐ I do NOT consent to having my photo/video taken or for my picture to be used by SHM.

_____ _____

Patient Name DOB

_____ _____

Patient Signature Date

Patient Rights

At Samaritan Health Ministries, we want you to understand your rights and to have the highest expectations when it comes to your care. While there will be times when it is not possible to achieve every goal during your visit, we are committed to providing the best care possible.

Be Treated with Respect We pledge to serve patients with consideration and without discrimination at all times.

Participate in Your Healthcare You have the right to all the information you need to make the best possible decisions, including treatment options and test results. You have the right to accept or reject a treatment plan. Your care will be improved if you participate in the decisions regarding your health.

To Privacy and Confidentiality, You have the right to talk in confidence with your healthcare providers and, within legal limits, to have your privacy protected at all time.
Samaritan Health Ministries is required by law to maintain the privacy of your health care information (Protected Health Information – PHI) and to educate our personnel concerning privacy and confidentiality.

Have a Family Member with You You may have a family member accompany you during your discussion with your healthcare provider.

Know the Names and the Titles/Roles of Our Staff We expect our staff to wear identification badges. If you do not see a badge, please feel free to ask any of us for our name and our role (providers, nurse, assistants, receptionist, etc.).

Be Examined In Private Your provider may be working with a healthcare student. You have the right to request that your examination be completed without anyone else in the room (unless a chaperone is required for sensitive exams).

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

_____ _____
Witness Date

Questions/Concerns

If you have any concerns about your visit to our clinic, you may:

- Tell us about your experience through one of our surveys
- Ask to speak to a supervisor
- Contact the Executive Director at smunoz@theshm.org

- Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, may be reported for investigation to:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC – 263
Austin, TX 78768-2018

Assistance in filing a complaint is available by calling (800) 201-9353
For more information, please visit the Texas Medical Board website.

- Complaints about nurses, as well as other licensees and registrants of the Texas Board of Nursing, including nurse practitioners, maybe be reported for investigation by requesting a complaint form at (512) 305-6838 or on the BON website
  BON complaints

The form can be returned to:

Texas Board of Nursing
Attention: Enforcement
Suite 3-460
333 Guadalupe St.
Austin, TX 78768
PHONE: (512) 305-6838
FAXED TO: (512) 305-6870
EMAILED TO: complaints@bon.texas.gov

Assistance for filing a complaint is available by calling (512) 305-7431

Complaints about Dental Health Care Personnel including Dentists, Hygienists and Dental Assistants.
Complaints may be submitted in one of the following manners:

1. By email. Email complaints to **complaints@tsbde.texas.gov**
2. By fax. Fax complaints to 512-692-2517
3. By mail. Mail complaints to:
   Texas State Board of Dental Examiners
   Attn: Investigations Division
   333 Guadalupe ST
   Tower 3, Suite 800
   Austin, TX 78701-3942