SHR A FAMILY OF HEALTHCARE CENTERS
SPECIAL HEALTH RESOURCES

Patient Registration Form

Our clinic is part of Special Health Resources (SHR), a Federally Qualified Health Center and all information requested is mandated for reporting and statistical purposes. All information is strictly confidential, meaning no identifying information will be released without your consent or otherwise permitted by the law.

Marketing

How did you learn about us? *(Please select all that apply):*

Advertising ☐ Community Event ☐ Family ☐ Friend ☐ Mobile Unit ☐ Online Search ☐ Other Provider ☐ Radio/Television ☐ Social Media ☐

Patient Information

First Name _____ Middle Name _____ Last Name _____ Date of Birth _____

Soc. Sec. or ITIN # _____ Driver's License or ID # _____ State Issuance _____ Mother's Maiden Name _____

Mailing Address, City, State, Zip Code _____ County _____

Home phone # _____ Cell phone # _____ E-mail address _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Separated ☐ Gender at birth: Male ☐ Female ☐

Preferred contact method: Home phone☐ Cell phone☐ Email☐

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting requirements. The options for some of these questions were provided by our funders; we understand that current demographic categories do not adequately capture our individual identities. Please help us serve you better by selecting the best answers to these questions. Thank you!

Sexual Orientation: Heterosexual (or Straight) ☐ Lesbian or Gay ☐ Bisexual ☐ Something else ☐ Don't know ☐ Prefer not to answer ☐

Gender Identity: Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Prefer not to answer ☐ Other ☐

Preferred Language: English ☐ Spanish ☐ American Sign Language ☐ Other ☐ _____ Do you need a translator? Yes ☐ No ☐

Agriculture worker? Yes ☐ No ☐ *Are you a Veteran?* Yes ☐ No ☐ *Ethnicity:* Hispanic/Latino ☐ Non -Hispanic/ Latino ☐

Race (check all that apply): Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Black/African American ☐
American Indian/Alaskan Native ☐ Prefer not to answer ☐

Experiencing Homelessness? Yes ☐ No ☐ If yes, select your current housing arrangements: Street ☐ Homeless Shelter ☐ Transitional ☐
Doubling up (*not paying rent*) ☐ Prefer not to answer ☐

Education Level: Less than High School ☐ GED/High School Diploma ☐ Beyond High School Diploma ☐ Prefer not to answer ☐

Responsible Party

Same as Patient ☐

First, Middle, and Last Name _____ Soc. Sec. # _____ Date of Birth _____

Relationship: Legal Guardian/Parent ☐ Power of Attorney ☐ Emancipated Minor ☐ (Please provide legal documentation for our files)

Mailing Address, City, State Zip Code _____ County _____

Home phone _____ Cell phone _____ Email address _____

Emergency Contact

Same as Responsible Party ☐

First and Last Name _____ Phone Number _____ Street Address _____

Relationship to Patient _____

SHR A FAMILY OF HEALTHCARE CENTERS
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Insurance & Payment Information

We receive funding to provide financial benefits to clients. By providing the information below we can determine your eligibility for these benefits.

Insurance Name: _____ Medicare ☐ Medicaid ☐ Group/Private ☐ None ☐

Employment Status: Full Time ☐ Part time ☐ Retired ☐ Disabled ☐ Self -Employed ☐ Public Assistance ☐ Unemployed ☐

_____ Name of Employer _____ Address _____ Phone #

Household Size (including patient & dependents): _____ Please circle the income that best represents your monthly income below:

$0 - $1,133	$1,134 - $1,506	$1,507 - $1,880	$1,881 - $2,264	$2,265
$0 - $1,526	$1,527 - $2,029	$2,030 - $2,533	$2,534 - $3,051	$3,052
$0 - $1,919	$1,920 - $2,552	$2,553 - $3,186	$3,187 - $3,837	$3,838
$0 - $2,313	$2,314 - $3,076	$3,077 - $3,839	$3,840 - $4,624	$4,625
$0 - $2,706	$2,707 - $3,599	$3,600 - $4,492	$4,493 - $5,411	$5,412
$0 - $3,099	$3,100 - $4,122	$4,123 - $5,145	$5,146 - $6,197	$6,198
$0 - $3,493	$3,494 - $4,645	$4,646 -$5,798	$5,799 - $6,984	$6,985
$0 - $3,886	$3,887 - $5,168	$5,169 - $6,450	$6,451 - $7,771	$7,772

Medical History

Immunizations/Vaccines

Please check the vaccines received at any point in your life. Please provide copy of your immunization/shot records, if available.

Influenza (flu) ☐ Human Papilloma Virus (HPV) ☐ Diphtheria, Tetanus &Pertussis (DTaP) ☐ Rotavirus (RV) ☐Pneumococcal (PCV13) ☐

Pneumococcal Polysaccharide (PPSV23) ☐ Inactivated Poliovirus (IPV<18) ☐ Meningococcal ☐ Meningococcal B ☐ Tetanus ☐ Shingles☐

Haemophilus Influenzae Type b (Hib) ☐ Hepatitis A (HepA) ☐ Hepatitis B (HepB) ☐ Measles, Mumps & Rubella (MMR) ☐ Varicella (VAR)

COVID-19 Vaccine ☐

Obstetrics/Gynecology

Are you pregnant? Yes ☐ No ☐ Maybe ☐ Date of last menstrual: _____
Are you using birth control: Yes ☐ No ☐ If yes, what type? _____
Date of last pap smear: _____ What was the result: Normal ☐ Abnormal ☐
Have you had a hysterectomy? Yes ☐ No ☐ If yes, what year? _____

Exam and Screening Tests

	Date	Result:		Date	Result
Mammogram	_____	Normal☐ Abnormal☐ Never done☐ N/A☐	Cholesterol Levels	_____	Normal☐ Abnormal☐ Never done☐ N/A☐
Colorectal Cancer Screening	_____	Normal☐ Abnormal☐ Never done☐ N/A☐	Chest X-Rays	_____	Normal☐ Abnormal☐ Never done☐ N/A☐
Diabetes - HgA1C	_____	Normal☐ Abnormal☐ Never done☐ N/A☐	Dilated Eye Exam	_____	Normal☐ Abnormal☐ Never done☐ N/A☐
Diabetes – Annual Foot Exam	_____	Normal☐ Abnormal☐ Never done☐ N/A☐	Prostate Screening / PSA	_____	Normal☐ Abnormal☐ Never done☐ N/A☐
Medicare Annual Wellness	_____	Normal☐ Abnormal☐ Never done☐ N/A☐	HIV Screening / Test	_____	Positive ☐ Negative ☐ Never done ☐ N/A☐

Caffeine Intake (includes coffee, tea and caffeinated beverages): Never☐ Rarely☐ Moderate ☐ Daily ☐ _____cups per day

Alcohol Intake (includes wine, beer, spirits, etc.): Never☐ Rarely☐ Moderate ☐ Daily ☐ _____drinks per day

Tobacco Use (includes cigarettes, cigars, e-cigarettes, chewing tobacco, etc.): Never☐ Rarely☐ Moderate ☐ Daily ☐

Excessive exposure at work or home to: Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ None ☐

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Consent for Care

I authorize the employees of this clinic, providing services under Special Health Resources, Inc. or under any or its DBAs, to render primary care and other related services. I understand that the clinic is committed to offering superior quality of care to all patients regardless of race, ethnicity, religion, sex, age, or disability status.

I understand that I will be fully informed of anticipated benefits, possible discomforts, and potential side effects prior to the performance of any medical treatment, and I release the clinic from any liability that may arise as the result of such treatment. I consent to examinations, treatments, procedures and blood test ordered by my Physician, NP, PA and other health care providers, including blood tests for communicable diseases such as Tuberculosis, Hepatitis and HIV/AIDS, etc. I authorize the clinic and its staff to send pertinent information about my prescriptions to the pharmacy(ies) of my choice.

I understand my health record and information related to my care at the clinic is confidential. I have been provided a Summary Notice of Privacy Practices that details the various ways that information about me may be disclosed for treatment, payment, healthcare operations, and other purposes permitted or required by law, as applicable. I understand that state law requires the reporting of certain positive results such as hepatitis and the antibody for the HIV virus to the health department. I authorize the release of any medical or other information necessary to process a claim for payment.

I understand that a minimal charge for services rendered (based on your eligibility) covering my office visit is expected at the time of service. Sources of acceptable payments are: Cash, ATM card (debit card) and Major Credit cards (MasterCard, VISA, Discover and American Express). My co-pay for: Medicare, Medicaid, CHIPs, and most Private Insurances, is expected at the time of the visit. If I need to set up a payment plan, the staff will provide information regarding this. If I am unable to afford my visit I may be able to apply for fee waiver. I can request fee waiving information and application from front desk or intake staff.

_____ I have read and understand the above information and hereby consent to care at the clinic. I further understand that if I qualify for Ryan White services it is the Payor of last resort. I understand that if I do not provide the required information and documentation instructed by SHR staff, regardless of program participation, I will be responsible for the charges and expected to pay 100% for all services rendered.

_____ I may qualify for the sliding fee scale regardless of insurance. The sliding fee scale is based on my household size and income. In order to qualify for the sliding fee scale, I must provide the information and documentation required by SHR staff. I understand that if I do not provide the necessary information, regardless of program participation, I will be responsible for the charges and expected to pay 100% for all services rendered. I can request copy of policy related to this matter.

_____ I consent to provide the clinic access to and use of my prescription medication history from other health care providers and/or third party pharmacy benefit payors for treatment purposes. Prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff at the clinic and may include prescriptions dating back several years. I understand that the clinic may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

_____ I consent to provide the clinic access and use of my Electronic Health Record with providers external to the organization via the health information exchange (CommonWell Health Alliance and Carequality Framework). I understand that this will expedite the interchange of medical information needed to provide a faster continuity to my medical treatment.

Patient Printed Name and Initials	Date of Birth
Signature of Patient/Legal Representative	Date
Staff Signature	Date

Electronic Communications Informed Consent Form

Name of Patient: _____ **Date of Birth:** _____

Person giving consent if different from Patient (Please Print): _____

Relationship to Patient: Self ☐ Parent ☐ Guardian ☐ Other ☐: _____

Clinic Site: _____

Risks of Communication by Email, Text Message, and Other Non-Secure Means:

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Receiving receipts for services by email or text message fall into this category as well. Be informed that these methods, in their typical form, are not confidential means of communication. If these methods to communicate are used, there is a reasonable chance that a third party may be able to intercept these messages. Some of the potential risks you might encounter using these methods of communication include:

- People in your home or other environments who access your phone, computer, or other devices that you use might read your email or text messages.
- Loss of cellular phone, computer, or other devices.
- Email accounts can be hacked.
- Text messages and emails are stored on servers.
- Misdelivery of email to an incorrectly typed address.
- Third parties on the Internet such as server administrators who monitor Internet traffic might intercept your communication.

Please limit the use of electronic communications to issues related to scheduling. If you choose to email us, please be aware that your email responses should be brief and SHR staff may call you to discuss the matter. SHR staff will not respond to text messages that are not related to scheduling, or outside of business hours.

Encrypted Email: You may choose to communicate with SHR through our practice software, which offers a more secure means of communication. To do so, register through the patient portal and obtain a login and password you can utilize to communicate with SHR staff via encrypted email. While it cannot be guaranteed that this form of communication will prevent 100% of confidentiality breaches, it is designed with the intention of supporting the confidentiality of clinical communications.

Please check the unsecured methods in which you approve/disapprove to be contacted:

May contact by telephone No ☐ Yes ☐ May contact by text No ☐ Yes ☐

May leave voice message No ☐ Yes ☐ May contact by email No ☐ Yes ☐

Receive receipts by:

Email ☐ Text ☐ Printed Receipt ☐ No Receipt ☐

Receive appointment reminders via:

Patient Portal ☐ Email ☐ Text ☐ Voice Message ☐ No reminders ☐

My signature below indicates I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Informed Consent for Telemedicine and/or Telehealth

In order to better serve the needs of the community, some health care services are available from the center via telemedicine and telehealth. Telemedicine medical services and telehealth services are health care services delivered by physicians and health professionals to patients (Patient is defined as any person receiving services from SHRT under/or any of its DBA) located at a different physical location using telecommunications or other information technology. Telecommunications or other information technology may also be used for virtual check-ins, e-visits, initial evaluations, screenings, and pre and post visit communication by center staff. Providers may include, but are not limited to, Physicians, Advanced Practice Registered Nurses, Physician Assistants, Professional Counselors, Marriage and Family Therapists, Clinical Social Workers and Psychologists; support staff includes but is not limited to: Registered Nurses, Vocational Nurses, Medical Case Managers and Eligibility Specialist.

Information shared may include patient medical records, medical images, medical audio or video files, two-way audio and video, and output data from medical devices. The systems used by the center to transmit and receive this information will incorporate network and software security protocols intended to protect the confidentiality of the patient's identity and information.

I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services via telemedicine and/or telehealth.

I understand the following:

- The same standard of care applies to health care services delivered via telemedicine and/or telehealth as applies to an in-person visit.
- The laws that protect the privacy and confidentiality of health care information apply to health care services delivered via telemedicine and/or telehealth.
- I will not be physically in the same room as my healthcare provider. I will be notified of, and my consent obtained, for anyone other than my healthcare provider present in the room.
- There are certain hazards and risks connected with all forms of treatment, regardless of the medium used, and my consent is given knowing this.
- There are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the telecommunications or information technology is not adequate, the visit may be discontinued.
- I have the right to refuse to participate or decide to stop participating in a telemedicine/telehealth visit at any time.
- I understand that this visit may need to be converted into an in-person visit for situations and/or cases that require a physical exam in order to determine a diagnosis and for appropriate treatment and care.
- The center and the center's healthcare providers have no liability or responsibility for the accuracy or completeness of the medical information submitted to them or for any errors in its electronic transmission.
- I may consent to my medical record or a report containing an explanation of the treatment provided being sent to my primary care physician.
- This informed consent for telemedicine and/or telehealth is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent in writting, or until the center changes its services and asks me to complete a new consent form.

Consent Provisions

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks to a minimum, risks can be unpredictable both in nature and severity.
3. I understand that midlevel providers (Physician Assistants and Advanced Practice Registered Nurses) may be involved in my treatment and I consent thereto.
4. I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require such.
5. I hereby voluntarily give my consent to receive health care services via telemedicine and/or telehealth.

Printed Name of Patient	Signature	Date
Printed Name of Parent/Guardian/Next of Kin	Signature	Date
Staff Printed Name	Signature	Date and Time

If patient is not available to complete by self, state reason patient unable to sign:

_____

If revoked:

Printed Name of Patient	Signature	Date and Time

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Pledge of Confidentiality

Confidentiality of all records and client information is essential. All information obtained in connection with the examination, care, referral or services provided to any person(s) by Special Health Resource Inc. or anys of its DBAs, and any of its employees, subcontractors or volunteers shall not, without the client's written consent, be disclosed. Except in cases required by the law. However information may be disclosed:

A. In statistical or other summary forms; or
B. In Case Reports, but only if the identity of the individual(s) described in the Report is not revealed and cannot be discerned.

Section 83.103 of the Health and Safety Code provides for both civil and criminal penalties against anyone who violates the confidentiality of persons protected under the law.
Special Health Resources, Inc. supports the need for confidentiality and will implement disciplinary action toward any person associated with Special Health Resources who violates confidentiality.

Clients, participants, board members, employees, subcontractors, volunteers and any other appropriate individual will receive a copy of this policy (902.00 Client Confidentiality). The statement will be read and discussed with the individual, the individual will then sign one copy of the policy statement that will be retained in that individuals file.

All persons participating on any Special Health Resources activity must be informed of our policy regarding confidentiality.

I have read this policy and agree to follow the guidelines about confidentiality and to protect everyone at Special Health Resources, Inc.. Confidentiality is protected by the Federal Law.

Printed Name _____

_____ _____
Signature Date

_____ _____
Witness Date

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Authorization and Acknowledgement Form

Permission for Disclosure to Family, Friends or Caregivers

I hereby acknowledge that I have received and reviewed the privacy notice of Special Health Resources. I understand that my claim may be filed electronically. I hereby authorize Special Health Resources to release information from my medical record to the extent necessary for payment and obtain reimbursement. In the event, that emergency medical treatment is necessary, I further authorize Special Health Resources to obtain copies of my medical record from this clinic or another facility by use of this written request or a telephone request. A photocopy of this release is as valid as the original. I hereby authorize any relevant health information to be given to *(Please initial and list the names of those to whom we may release relevant health information to, and to act on behalf of the patient i.e. legal guardians approving family and friends to bring the patient for medical appointments):*

Initials	Full Name and phone number	Relation
Initials	Full Name and phone number	Relation
Initials	Full Name and phone number	Relation
Initials	Full Name and phone number	Relation
Initials	Full Name and phone number	Relation

Authorization to Be Treated By A: Physician Assistant or Nurse Practitioner

_____ I consent to be treated by a Physician Assistant/ Nurse Practitioner. I understand that a Physician Assistant/ Nurse Practitioner are NOT a physician. They are a graduate of a certified training program and are licensed by the State Board. Under the supervision of a physician, they can diagnosis, treat and monitor common acute and chronic disease as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervision physician, but rather overseeing the activities of and accepting responsibilities for the medical services provided. I understand that I can at any time request to see a physician for my health care needs.

Acknowledgement of Receipt of Patient Bill of Rights and Responsibilities, Patient Agreement and Complaint or Grievance Process of Special Health Resources

I have received information prior to receiving services, both verbally and in writing regarding my rights and responsibilities while at a Special Health Resources clinic. The information provided included my rights and responsibilities as a patient and the procedures for filing a complaint or grievance. By signing this document, I acknowledge that I have been provided the above verbally and written information, in advance of seeing a provider and I have read and understand its contents.

Patient Printed Name	Date of Birth
Signature of Patient/Legal Representative	Date
Staff Signature	Date

SHR A FAMILY OF HEALTHCARE CENTERS
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Notice of Privacy Practices

This notice describes how protected health information (PHI), or medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosure:

Information that describes your health status, including basic demographics and the use of services will be used to make prevention, intervention or treatment decisions. Specifically, Special Health Resources (SHR) may use and disclose protected health information without specific authorization for the following:

1. To conduct the client's treatment,
2. To obtain payment for services provided to the client from the client's health plan, to process credit card transactions, or for other payment-related purposes (i.e., filing a claim for payment to Blue Cross Blue Shield),
3. In the day-to-day operations of Special Health Resources (i.e., schedule appointments).

Special Health Resources has the duty to report suspected child/elder abuse, domestic violence, human trafficking, threats to harm self or others, or as otherwise mandated by law. Any other use or disclosure of protected health information requires written authorization by the consumer, and that authorization may be revoked by the consumer.

Patient Rights and Responsibilities:

Special Health Resources believes that patients want to understand and participate in their healthcare. We also believe that patients can better participate if they know what their rights and responsibilities are. The following statement summarizes these rights and responsibilities for our patients, their families and their friends.

Care

The patient is under the care and supervision of a provider. It is the responsibility of the facility and its staff to carry out the instructions of the intermediate care providers and/ or physicians.

Patient Responsibilities

1. ***Consideration***: All patients are responsible for following clinic rules and regulations and for being considerate of the rights of others while at the clinic. Please help us by controlling noise and observing our no-smoking policy.
2. ***Giving Information:*** You are responsible for providing accurate and complete information about your health and for reporting changes in your condition.
3. ***Following Instructions:*** You are responsible for following the treatment plan recommended by the doctors, intermediate health providers, nurses and other care givers and for reporting to your provider the side effects of any treatments. If you refuse treatment or fail to follow the directions of your provider and/or other clinic personnel, please understand that you are responsible for your own actions.

Patient Rights

1. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
2. You have the right to be free from abuse, neglect, and exploitation;
3. You have the right to be treated with dignity and respect;
4. You have the right to be informed before treatment about the procedure, risks, side effects, and benefits of all medications and/or treatment you will receive, other treatments that are available, and possible consequences if you refuse treatment. You will make a decision for your treatment using an informed consent outlining:
    a. The condition to be treated;
    b. The proposed treatment;
    c. The risks, benefits, and side effects of all proposed treatment and medication;
    d. The probable physical and mental health consequences of refusing treatment; and
    e. Other treatments that are available and which ones, if any might be appropriate for you; and,
5. You have the right to accept or refuse treatment after receiving this explanation.
6. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
7. You have the right to assist in the development of a care plan designed to meet your needs.
8. You have the right to refuse to take part in research without affecting your regular care.
9. You have the right to privacy, which means that information about you will be kept private. As well, you shall be informed of the cases when the information can be released without your permission.

10. You have the right to be informed in advance of all estimated charges and any limitations on the length of services that the facility is aware of.
11. You have the right to make a complaint and receive a fair response from the clinic within a reasonable amount of time.
12. You have the right to complain directly to the Department of State Health Services from the respective state where you received services.
13. You have a right to get a copy of these rights before you are treated, along with pertinent policies upon your request.
14. You have the right to have your rights explained to you in simple terms.
15. Termination of Care. When evidence of violation(s) to the patient and center rights and responsibilities, defined here and in the organization's policies, and the SHR considers that the most appropriate action is to stop the patient-SHR relationship, you have a right to receive advance written notice that explains the reason for such decision, and you will be given thirty (30) days to find other health care services. However, the center can decide to stop treating you immediately, and without written notice if you have created a threat to the safety of the staff and/or other patients. You have a right to receive a copy of the center's policy "Termination of Consumer-SHR Relation". Reasons for which we may stop seeing you may include, but are not limited to:
    a. Intentional failure to accurately report your financial status;
    b. Intentional failure to report accurate information concerning your health or illness;
    c. Failure to obey center rules and policies, such as keeping scheduled appointments;
    d. Intentional failure to follow the health care program, such instructions about taking medications, personal health practices, or follow up appointments, as recommended by your healthcare provider(s), and/or creating a threat to the safety of the staff and/or other patients.

Individual Rights

1. As a client of Special Health Resources, you have the following rights under the federal privacy rule:
2. The right to request restrictions,
3. The right to receive confidential communications,
4. The right to inspect their chart by requesting a copy of their protected health information,
5. The right to amend protected health information,
6. The right to receive an accounting of disclosures, which pertain to disclosure for reasons other than treatment and payment;
7. The right to receive a printed copy of the Notice of Privacy Practices itself.

Special Health Resources Responsibilities:

The health center maintains the privacy of protected health information, distributes the Notice of Privacy Practices to clients prior to providing services, and abides by the terms of that notice.

Right to Revise Privacy Practices:

Special Health Resources reserves the right to modify its privacy practices and should it do so, the revised notice will be made available to clients upon their request.

Complaints:

You may file a complaint or report a suspected violation concerning the Special Health Resources, Inc. privacy practices by completing a Consumer Problem Resolution Form, and submitting the completed form to Special Health Resources Privacy Officer (aka Compliance Officer) via mail, in-office or electronically. Special Health Resources will not retaliate against anyone for submitting a complaint or reporting a suspected violation.

Contact Person:

Compliance Officer
Special Health Resources, Inc.
2020 Bill Owens Parkway, Suite 220.
Longview, TX, 75601
903-212-7808

Electronic Submission:

https://www.surveymonkey.com/r/HMB5LXB

With the State

Complaints about physicians and other licensees and registrants of the Texas Medical Board:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018
1-800-201-9353
www.tmb.state.tx.us.

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Special Health Resources Patient Agreement

As a member of the Special Health Resources Medical Home Team, I, the patient or guardian, will:

- Let my Special Health Resources team know at least 24 hours in advance when I am unable to keep a scheduled appointment.
- Let my Special Health Resources team know when I have moved or changed phone numbers, so my contact information is correct.
- Call the pharmacy for medication refills at least six (6) business days before running out of the prescription.
- Treat Special Health Resources team members with respect as we partner together for care.
- Provide my Special Health Resources team feedback so services can improve.
- Take medications as prescribed and follow the treatment plan; if I cannot do this, I will let my Special Health Resources team know.
- Inform the Special Health Resources team when I see providers outside of Special Health Resources and tell my team: which medications were prescribed or changed, what tests or treatments were done, and any other services performed related to my health.
- Understand my health risks and conditions; ask questions and learn ways to improve my health and prevent illnesses.
- Provide my Special Health Resources team any information regarding: health condition, medical history, illnesses, medications (including over the counter/herbal or supplements), visit with specialists, recent test results, ER visits, and hospital stays.

The Special Health Resources team will continue, for you as a patient or guardian, to:

- Respect you as an individual—we will not make judgments based on race, religion, gender, sexual orientation, gender identity, age or disability.
- Respect your privacy; medical information will not be shared with anyone unless you give us permission or it is required by law.
- Provide evidence-based care by a team of people (nurses, social workers, medical assistants, nutritionists and support staff) led by your responsible provider who will watch over all your care.
- Give care that meets your needs and fits with your goals and values.
- Answer your calls and questions as soon as possible, even after normal business hours; 24 hours a day, 7 days a week.
- Remind you when it is time to have any check-ups or tests. Help you stay healthy by teaching you to make better choices.
- Improve your care by using technology—like Electronic Health Record and always strive to improve Special Health Resources' services.
- Help you get the care needed, even if it is outside of the Special Health Resources team.