COMMUNITY HEALTH NETWORK

1111 West Adoue Street ◦ Alvin, Texas 77511 ◦ Ph: 281-824-1480 FX: 1-877-489-2319 ◦ www.sfachc.org

Please ask for assistance if you need help with reading or understanding this document.
If you would like a printed copy of this document, please ask and a copy will be provided for you.
PLEASE FILL OUT THE ENTIRE FORM FILLING IN ALL FIELDS. USE "NOT APPLICABLE" OR "N/A" IN FIELDS THAT DO NOT APPLY. PLEASE SIGN AND DATE ON THE LAST PAGE.

Patient Name		Date	
Guardian or Patient Representative	Not Applicable	Relation	Not Applicable

Patient and Center Rights and Responsibilities

Welcome to Stephen F. Austin Community Health Network, Inc. (SFACHN). Our goal is to provide quality health care to under qualified persons in this community regardless of their ability to pay. If we were enrolling new patients you may be eligible to become our patient. As a patient, you have the rights and responsibilities to you. We want to understand these rights and responsibilities so you can help us provide better health care for you. Please read this statement and ask us any questions you might have.

Human Rights:

1. You have a right to be treated with respect and dignity regardless of race, religion, national origin, sexual orientation, political affiliation, or ability to pay for services.

Treatment for Services:

2. You are required to complete the registration process to determine if you are eligible for discounted fees for services. You are required to give us accurate information about your present financial status and any changes in your financial status as they occur.
3. You have a right to receive explanations of your bill. You must pay, or arrange to pay, all agreed fees for medical, dental, or behavior health services, as provided by our policies.
4. Federal law prohibits us from denying you primary health care services, which are medically necessary solely because you cannot pay for these services. However, you are responsible for your fees and need to act in good faith to make arrangement for services provided.

Privacy:

5. You have the right to have you interviews, examinations and treatments in private. Your medical records are kept private. Only legally authorized persons may see your record unless you request in writing for us to show them to someone else. A complete discussion of your privacy rights is attached in the "Notice of Client Privacy Rights". By signing this document, you are indicating that you have received this notice. The notice details the various rights granted to you under the Health insurance Portability and Accountability Act.

Healthcare:

6. You are responsible for providing us with complete and current information about your health or illness so we can provide you with proper health care. You have the right to, and are encouraged to participate in decisions about your treatment.
7. You have the right to information and explanations in the language you normally speak and in words that you understand. You have the right to information about your health or illness, treatment plan (including risks) and expected outcome, if known. If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to legally authorized person.
8. You have the right to information about Advanced Directives. At this time, would you like information about Advance Directives? ☐ Yes ☒ No If yes, additional information will be provided to you. If you stated no, you may request this information at another time.
9. You are responsible for appropriate use of our services, which includes following our staff's instructions, making and keeping scheduled appointments, and only requesting a "walk-in" appointment when you are ill. We may not be able to see you unless you have an appointment. If you do not understand or cannot follow the staff's instructions please tell us so we can help you.
10. If you are an adult, you have the right to refuse treatment to the extent permitted by law, and to be informed of the risks of refusing such care. You are responsible for the outcome of refusing treatment.
11. You have the right to health care and treatment that is responsible for your condition and within our capability. You have the right to be transferred or referred to another facility for services that we cannot provide. However, SFACHN is not required to pay for services that you get elsewhere. NOTE: SFACHN is not an emergency facility.
12. If you are in pain, you have the right to receive appropriate assessment and management as necessary. You may be asked to see a pain management specialist.

SFACHN Rules:

13. This form describes our rules about how to appropriately use our services. You are responsible for using our services in an appropriate manner. You may not abuse SFACHN property or services. It is the expectation of SFACHN that you and your family will treat the employees and facility with respect. If you have any question about using our SFACHN services, please ask.
14. You are responsible for the supervision of children you bring to SFACHN. You are responsible for their safety and the protection of their clients and our property. We are not responsible for children left unattended.
15. You have a responsibility to keep your scheduled appointments for three (3) consecutive times. You will be sent a warning letter and any additional missed appointments may lead to termination of services.

Complaints:

16. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. We will tell you how to file a complaint. Completes Client Suggestion/Complaint forms shall be reviewed by the appropriate supervisor. You shall receive a response by mail or phone regarding the outcome of your complaint or suggestion. If you are not satisfied with how we handle you complaint, you may file a complaint with the Board of Directors.
17. We will not punish you for filing a complaint and will continue to see you as a patient.

Termination:

18. SFACHN can decide to stop treating you as a patient. If we stop treating you as a patient, you have a right to advance notice that explains the reason for the decision, after notice of termination, we will only provide urgent care for a 30-day period while you find a new provider. We can decide to stop treating you immediately and without notice, if SFACHN has determined that you have created a threat to the safety of the staff and/or other clients. You also have a right to receive a copy of SFACHN's termination policy. Other reasons for which we may stop seeing you include:
    A. Failure to obey SFACHN rules
    B. Intentional failure to report accurate information concerning your health.
    C. Intentional failure to follow the health care program, such as instructions about taking medications
    D. Creating a verbal or physical threat to the safety of the staff and/or other clients and or
    E. Intentional failure to accurately report your financial status

19. If we have given you notice of termination, then you have the right to appeal the decision to the Board of Directors within 30 days of receipt of that notice.

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Patient Name		Date	
Guardian or Patient Representative	Not Applicable	Relation	Not Applicable

Consent for Medical Treatment

I DO ☒ I DO NOT ☐ NOT APPLICABLE ☐ authorize Stephen F. Austin Community Health Network to provide me with medical treatment.

I DO ☐ I DO NOT ☐ NOT APPLICABLE ☒ authorize Stephen F Austin Community Health Network to provide my child with medical treatment.

I DO ☐ I DO NOT ☐ NOT APPLICABLE ☒ authorize the following (listed below) to bring my child to Stephen F Austin Community Health Network for medical treatment.

Please list name and relationship to patient		
Name:		Relationship:
1	Not Applicable	Not Applicable
2	Not Applicable	Not Applicable
3	Not Applicable	Not Applicable

HIV Consent

I have been offered the blood test for detection of antibodies to the Human Immunodeficiency Virus (HIV) performed by an outside laboratory. HIV is the causative agent of Acquired Immune Deficiency Syndrome (AIDS).
I understand that this test many not be conclusive because a positive result means additional tests may be needed and a negative result does not necessary eliminate consideration of AIDS. I have also been informed that the results of this blood test will only be released to those healthcare personnel and insurance companies providing medical care and coverage to me as allowed by federal and state law. I understand that these test results will be a part of my medical records and will be release if I have signed and authorization for release of medical information.
I understand that not all health insurance plans will pay for HIV testing. Should my insurance company decline coverage, I understand that I will be expected to pay for it myself.
I am aware that additional information regarding HIV/AIDS and antibody testing is available at my request and therefore acknowledge that I have had the opportunity to ask any questions I have regarding this test prior to giving my consent.

☐ **I hereby give my consent for the performance of the HIV blood test and to the release of results as outlines above**

☐ **I decline the opportunity for the HIV blood test at this time. I have the option to be tested in the future if I choose and will notify the Center of that decision.**

Consent for Treatment w/ Clinical Extern

☒ **I DO hereby authorize Stephen F Austin Community Health Network's Extern students/Preceptor student to provide me or my child with medical treatment.**

☐ **I DO NOT hereby authorize Stephen F Austin Community Health Network's Extern students/Preceptor student to provide me or my child with medical treatment.**

Informed Consent for Medical Treatment

You have the right to be informed about your condition and your recommended medical treatment plan. This allows you to make an educate decision regarding the procedure and decide to give or withhold your consent.

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Guardian or Patient Representative	Not Applicable	Relation	Not Applicable

Authorization for Release of Protected Health Information (PHI)

NOTICE:
SFACHN is required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentially laws.

PATIENT RIGHTS:
I understand that I may refuse to sign this authorization and that is strictly voluntary. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. I may also revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.

Not Applicable	Not Applicable
Name	Relationship to Patient
Not Applicable	Not Applicable
Name	Relationship to Patient

TYPE OF RECORDS: ☑ Medical ☐ Behavioral Health ☑ Dental

INFORMATION TO BE RELEASED
☐ Entire Medical Record ☐ Medication Records ☐ Pathology Report ☐ Itemized Bill
☐ Medical Record, excluding Not Applicable
☐ Verbal release of entire medical record
☐ Verbal release of listed medical records only Not Applicable

EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this Authorization expires . If no date is indicated, the Authorization will expire 12 months after the date of signing this form.

SIGNATURES
I have read the above and authorize the disclosure of the protected health information (PHI) as stated.
PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
I acknowledge I have read the Notice of Privacy Practices of *Stephen F. Austin Community Health Network* and at any time I can request a copy of the Notice of Privacy Practices.

Patient Signature	Patient Name	Date
	Not Applicable	Not Applicable
Guardian or Patient Rep. Signature	Guardian or Patient Rep. Name	Relation
Staff Signature	Staff Title	Date

Save As Clear Form