HealthPoint - Rockdale ISD Clinic

Dear Rockdale ISD Families,

Rockdale ISD and HealthPoint are excited to announce a new collaboration that will make healthcare services available at a school near you! Our school-based clinics offer access to HealthPoint providers, with a wide range of telehealth services for acute care needs designed to make getting healthcare as easy as walking down the hall or visiting a nearby campus. In addition, HealthPoint providers will provide scheduled wellness visits, including immunizations, flu shots, and other services, periodically throughout the school year.

Rockdale ISD students, faculty, and staff are welcome to take advantage of these services, which include telehealth acute care, well-child check-ups, sports physicals, health education on nutrition, disease and injury prevention, vaccinations, and prescriptions as needed. The clinic is open on each campus during regular Rockdale ISD school hours. Parents/Guardians can participate in the visit by coming to their child's designated campus via telephone or video conference or receive a detailed post-appointment report.

HealthPoint's School-based clinics for Rockdale ISD provide care to registered students and current RISD faculty and staff only.

Register yourself or your child today by filling out and returning the attached paperwork in one of the following ways:

1. Scanned and emailed to RockdaleISD@HealthPoint-tx.com
2. In a sealed envelope to your child's campus
3. Delivered to HealthPoint – Rockdale Clinic: 1701 Pecos Ave, Rockdale, TX 76567.

HealthPoint accepts all major insurances, CHIP, Medicaid, Medicare, and has eligibility specialists available daily. HealthPoint also offers an income-based sliding fee scale for those who do not have insurance. **Be sure to include a copy of your ID and your insurance card(s) if you have them to avoid delays.**

Rockdale ISD and HealthPoint thank you for trusting us to care for your children daily. If you have questions or concerns, don't hesitate to contact either Keari Spence with RISD at (512) 430-6200 or your child's HealthPoint campus clinic at (512) 883-4370. For any concerns or feedback, please contact the HealthPoint Director of ISD Programs, Jennifer Reynolds, at (979) 209-9955.

Sincerely,
Terri Sabella
HealthPoint, CEO

Registration packets available here:

Student, Sibling, Faculty & Staff Registration Form

We do not discriminate against any person on the basis of race, color, national origin, sex, age, religion, or disability, in our programs and services

Patient Information

Last Name: First Name:

Date of Birth: SSN: Primary Language:

Gender: ☐ Male ☐ Female ☐ Other School: Grade:

Status: ☐ Current Student ☐ New Student ☐ Sibling of Student ☐ Faculty/Staff ☐ Faculty/Staff Child

Mailing Address:

Home Phone: Work Phone: ext:

Cell Phone: E-mail Address:

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ E-mail ☐ Mail

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown

Race: *-Check all that apply* ☐ White (includes Hispanic or Latino) ☐ Black or African American ☐ American Indian / Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Do not wish to report

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Insurance or Payment Source

Be sure to send copies/photos of insurance cards with completed forms to avoid registration delays. If you do not have insurance, please schedule an eligibility appointment by calling: 979-567-7080

☐ Medicaid ☐ CHIP ☐ Medicare ☐ Private Pay (self-pay) ☐ Other

☐ Insurance - *Name* ☐ Medicare with Supplement Insurance - *Name:*

Employment & Household Information

☐ Full-time ☐ Not Employed ☐ Active Duty Military

☐ Part-time ☐ Retired

☐ Self Employed ☐ Student

Household size:

Gross Income: Per - ☐ WK - ☐ MO - ☐ YR

Responsible Party

☐ Self (*patient listed above*)

☐ Guarantor; please complete the following details:

Please notify me before each visit: ☐

Last Name: First Name:

Date of Birth: Relationship to patient:

Address:

Best Contact Telephone Number: ☐ Home ☐ Cell ☐ Work

Emergency Contact

Last Name: First Name:

Home Phone: Work Phone: ext:

Cell Phone: Relationship to patient:

Preferred Pharmacy:

Pharmacy Name:

Address:

☐ I acknowledge my responsibility to pay for services rendered and understand that I will be responsible for any fees that are not paid by my Insurance or covered by HealthPoint programs.

Please initial

GENERAL CONSENT FOR TREATMENT

The information in this consent form outlines your rights, as our patient, to be informed about your condition and the recommended medical or diagnostic procedures your provider may use throughout the course of your relationship with HealthPoint.

I, _____,
(RESPONSIBLE PARTY'S PRINTED NAME)

born on _____ _/_____/_____,
(PATIENT'S DATE OF BIRTH)

consent to and request that my health care provider, along with any necessary staff, perform reasonable and necessary medical examinations, tests, and treatments for the purpose of assessing and managing any conditions or illnesses that I currently have or may develop.

I understand that HealthPoint is a primary care clinic that focuses on preventative healthcare. I acknowledge that only a limited number of these primary care examinations, tests, or treatments require disclosure of specific risks, as required by the Texas Medical Disclosure Panel; should my health care provider recommend a treatment that requires disclosure of specific risks, I will be asked to sign additional documents indicating that I have been advised of the specific risks and hazards of the recommended procedure or treatment.

I understand there are certain risks or hazards associated with any form of treatment or test, and that I have not been made any guarantee about a result or cure from any treatment or test provided by HealthPoint or its staff. I further acknowledge that HealthPoint does not assume any responsibility, financial or otherwise, for services or care received outside of HealthPoint.

I acknowledge that minimally necessary information may be released by HealthPoint in order to comply with Federal and State law, including the Health Insurance Portability and Accountability Act of 1996 and the Texas Medical Records Privacy Act.

Additionally, limited information may be released to certain Federal and State agencies that provide funding to HealthPoint in order to ensure compliance with legal responsibilities.

I understand that HealthPoint is a federally deemed facility under the Federal Torts Claims Act, meaning that HealthPoint is considered a part of the federal government for the purposes of civil liability.

This consent will remain in effect until I withdraw my consent. If HealthPoint changes the nature of its services, or it has been at least two years since my last appointment, I will be asked complete another general consent for treatment.

I have been given the opportunity to ask questions regarding this consent, and I certify that this form has been fully explained to me and that I understand its contents.

_____
SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED PERSON

_____
NAME OF OTHER LEGALLY AUTHORIZED PERSON
(if applicable)

_____
RELATIONSHIP OF LEGALLY AUTHORIZED PERSON TO PATIENT
(if applicable)

_____/_____/_____
TODAY'S DATE

Created: 12.19.2018
Revised: 07.25.2022

PATIENT RIGHTS & RESPONSIBILITIES

Patient Name: _____

Date of Birth: _____/_____/_____

Welcome to HealthPoint!

Our goal is to provide the highest quality health care that is both affordable and accessible to all. As a patient, you have rights and responsibilities. The center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read and sign this statement and ask us questions you might have.

Your Rights as Our Patient:

Nondiscrimination

- You have the right to be treated with respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age, veteran status, or other grounds, as provided by federal, state, and local laws or regulations.

Payment

- While all patients of federally qualified health centers are expected to financially participate in their health visits, you will not be denied services due to an inability to pay at the time of the visit. The clinic can assist you by screening you for eligibility to participate in various state and federal programs that pay for some or all your health visits, as well as providing options for payment plans.

- You have the right to receive explanations about the bill you received from the clinic.

Privacy

- You have the right for your interviews, examinations, and treatment to be conducted in privacy. Your medical records are also private.

- You have the right to receive a complete discussion of your privacy rights as our patient in the form of our "Notice of Patient Privacy Rights"; this document provides a comprehensive review of the ways in which we may use or disclose your medical records. By signing the "Patient and Center Rights and Responsibilities" you are acknowledging that you have received and understood our "Notice of Patient Privacy Rights."

Health Care

- You have the right, and are encouraged, to participate in decisions about your treatment.

- You have the right to information about your health or illness, and your treatment plan, including: the nature of your treatment; its expected benefits; its inherent risks and hazards (and the consequences of refusing treatment); the reasonable alternatives, if any (and their risks and benefits); and the expected outcome, if known. After being informed of this information and providing your consent, you are giving us what is known as "informed consent."

- 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 receive information regarding "Advance Directives." 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 your legally authorized representative.

- If you are an adult, you have the right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. You have the right to be informed of the risks, hazards, and consequences of your refusing such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed."

- You have the right to health care and treatment that is reasonable for your condition and within our capability.

- However, the center is not an emergency care facility. You have a right to be transferred or referred to another facility for services that the center cannot provide. The center does not pay for services that you receive from another healthcare provider.

- If you are in pain, you have the right to receive an appropriate assessment and pain management, as necessary.

Center Rules

You have the right to receive information on how to appropriately use the center's services. If you have any questions, please ask us.

If the center decides that we must stop treating you as a patient, you have the right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find another primary care provider.

You have the right to receive a copy of the center's "Noncompliance and Termination" Policy and Procedure.

If the center has given you notice of termination, you have the right to appeal the decision to the Medical Director.

Complaints

You have the right to tell us how we can improve the services that we offer you. Staff will tell you how to make a suggestion or file a complaint. If you are not satisfied with how the staff handles your situation, you may contact the center's administration.

Although we encourage you to bring your concerns directly to us, you always have the right to take any complaint to the Texas Department of State Health Services or Health and Human Services.

Payment

- You have the responsibility to give staff accurate information about your present insurance and/or financial status, as well as any changes in your insurance and/or financial status. The staff need this information to determine your financial responsibility and/or so they can bill private insurance, Medicaid, Medicare, or determine other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, you will be charged a nominal fee.

- You have the responsibility to pay, or arrange to pay, all agreed fees for medical and dental services. If you cannot pay right away, please let staff know so arrangements can be made.

Privacy

- You have the responsibility of informing us of the people, if any, that may or may not access your medical records. It is important that we know this information from the beginning of your relationship with us so that we can avoid any future confusion. Staff can provide you a form to indicate those people you are granting access to your private medical record.

- If you are a parent or legal guardian, please let staff know if someone other than yourself or the child's legal guardian may be bringing the child to receive services.

Health Care

- You have the responsibility for providing the center complete and current information about your health or illness, so that we can give you proper health care.

- You have the responsibility for assuming the consequences and outcomes of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in your best interest, you may be asked to sign the center's "Patient Declination of Care" form.

- You are responsible for appropriate use of center services, which includes following staff instructions, and making and keeping scheduled appointments. Center professionals may not be able to see you unless you have an appointment.

Center Rules

- You have the responsibility to use the center's services in an appropriate manner – this means you must conduct yourself respectfully to all staff and fellow patients at all times while you are accessing clinical services. Threatening, abusive, violent, fraudulent, intentionally offensive, or any unlawful behavior will not be tolerated. If your behavior is deemed to consistently or permanently disrupt the relationship between your healthcare provider and yourself, then your relationship to the center may be terminated pursuant to the center's policies and procedures.

- You have the responsibility to supervise the children that you bring with you to the center.

- You have the responsibility for your children's safety, and the protection of other patients and our property.

- You have the responsibility to keep your scheduled appointments. Missing scheduled appointments causes delay in treating other patients. If you do not keep scheduled appointments and/or fail to provide timely notification to the center, pursuant to the center's policies and procedures you may lose the privilege to schedule future appointments.

HealthPoint's Rights as Your Provider

Privacy

- In certain instances, HealthPoint may be required to disclose your medical records to State or Federal agencies for the purposes of mandatory reporting or investigations.

- The center may also be compelled to disclose your medical records pursuant to a valid court order.

- HealthPoint has the right to stop treating you as a patient if you commit a substantial violation of the center's rules.

- HealthPoint has the right terminate its relationship to you immediately and without
- written warning if you create a threat to the safety of the center's staff or other patients.

HealthPoint's Responsibilities as Your Provider

Generally

- HealthPoint has the responsibility to ensure that you are provided with quality care in an environment that protects and promotes your rights as our patient.

Complaints

- HealthPoint has the responsibility to ensure that no center representative will punish, discriminate, or retaliate against you for filing a complaint, and the center will continue to provide you services.

_____

SIGNATURE OF PATIENT OR AUTHORIZED PERSON

_____

NAME OF AUTHORIZED PERSON (if applicable)

_____

RELATIONSHIP OF AUTHORIZED PERSON TO PATIENT (if applicable)

_____/_____/_____

TODAY'S DATE

Created: 12.19.2018
Revised: 07.25.2022

Last Name: _____

CONSENT TO TREAT A MINOR (STUDENT)

With few exceptions, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

You may appoint anyone who is over the age of 18 to be responsible for your child when you are unable to accompany them to their medical appointment at the school-based clinic operated by HealthPoint.

Minor's Full Name _____
Last Name First Name Middle Name

Date of Birth _____ Campus _____

By signing this form, you give us permission to provide the following services or treatment(s) to your child:

- Family and home support
- Health care, including immunizations
- Dental health care
- Health education
- Preventive health strategies

Initial here if you wish to give consent for the minor listed above to receive medical care without an accompanying adult.

Students will not be seen without a parent/guardian calling for an appointment or parent/guardian being notified of the need for an appointment.

This consent only permits the treatment(s) indicated above. If other treatment or procedures need to be performed, additional consent must be obtained from an individual authorized to give such consent, in accordance with the Clinic's consent policies.

As a courtesy, insurance claims will be filed by HealthPoint. Contractual limitations and obligations will apply. Parent/Legal Guardian will be responsible for the patient portion of their bill.

This consent will be effective for the _____school year beginning _____or until revoked by written communication. I have read, understand, and give my consent as stipulated above.

Parent, Legal Guardian, or other person having lawful control over minor child:

_____ _____
Signature Relationship to Minor Child

Date Signed: _____ Phone #:_____

Minor's Full Name: _____
Last Name First Name Middle Name

List the names of the minor child's parents, legal guardian, and/or any managing conservator:

_____	_____
Name & Phone Number	Relationship to Minor Child
_____	_____
Name & Phone Number	Relationship to Minor Child
_____	_____
Name & Phone Number	Relationship to Minor Child

Date	Signs/Symptoms	Parent/Guardian Contacted	Phone #	By

Revised: 07.25.2022