HOPE Alief
Health & Wellness Center
13930 Bellaire Blvd.
Houston, Texas 77083

HOPE Clinic Aldine
3000 Aldine Mail Route Rd.
Building C, Suite 200
Houston, Texas 77039

HOPE Aldine Meadows
School Based Clinic
2112 Aldine Meadows Rd.
Houston, TX 77032

HOPE Clinic Beltway
7001 Corporate Drive
Suite 120
Houston, TX 77036

HOPE Clinic West
12121 Westheimer Rd.
Suite 205
Houston, Texas 77077

HOPE Clinic Appoinment Policy

My signature below acknowledges I have been offered a Patient Information Package, which includes a:

- Notice of Privacy Practices, explaining how my health information will be handled in various situations.
- Statement of Client Rights and Responsibilities, which I agree to abide by.
- Feedback/Concern/Complaint/Grievance Policy for filing complaints.
- E-Prescribing Information Sheet; and
- HOPE Patient Agreement

Consent to Treatment, Testing, Immunizations and Procedures

I consent to all tests, treatments, immunizations and procedures ordered by HOPE providers including, without limitation, testing for communicable or blood-borne diseases such as sexually transmitted diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis. As part of my testing and treatment, I may receive disease-specific prevention, education, and risk-reduction services. I understand that HOPE is required by state law to report information to the City of Houston Department of Health & Human Services for persons who test positive for certain diseases (known as "reportable diseases"} including, but not limited to, tuberculosis, HIV/AIDS, and syphilis. If I test positive for a reportable disease, I understand that I will be contacted by a state-authorized Disease Intervention Specialist to promote successful treatment and notification of any sex partners, if applicable, who may be at risk for the disease. I also understand that if a HOPE health care worker is accidentally exposed to my blood or body fluids, (for example by a needlestick), HOPE can draw and/or use blood drawn from me for testing purposes.

Financial Responsibility

I understand that if I qualify for services through a grant funded program such as Ryan White or the Department of State Health Services Family Planning (Title X) these resources are payers of last resort. As payers of last resort, grant-funded programs may not continue my eligibility if I currently or in the future have Medicare, Medicaid and/or third-party insurance coverage. Therefore, I agree to immediately report any changes in my financial status and/or insurance coverage to the Eligibility Specialist. If I fail to appropriately report changes in my financial status and/or insurance coverage, and if those changes result in my ineligibility for services under a grant funded program, I understand that I am fully responsible for the cost of services delivered by HOPE.

Insurance Assignment

By signing below, if I am eligible for Medicaid, Medicare and/or third-party insurance coverage while a client of HOPE, I authorize HOPE to furnish to Medicaid, Medicare and/or third-party insurance coverage all of the necessary information, including my HIV status, to process my claim. I also hereby assign to HOPE all payments received from Medicaid, Medicare and/or a third-party insurer for services and treatments provided to me by HOPE. I understand that I may be responsible for paying any required co-payments prior to being seen by a health care practitioner. I also understand that I am responsible for the cost of services and treatments delivered to me that are not covered by my insurance.

Research Participation

HOPE participates in research studies, which can involve proven or experimental treatments. By signing below, I authorize HOPE staff to review my information to determine if I qualify to participate in current or future studies. If I qualify, I will be notified and provided with the opportunity to accept or decline research participation. My signature below does not mean I agree to be in a research study.

Value Based Care

HOPE participates in value-based care initiatives with insurance providers and state/national agencies in order to improve the quality of care for patients. I understand that HOPE clinic may offer participation in programs for quality care and contact me about these programs. HOPE will securely share my information with insurance providers in order to participate in these types of programs. HOPE is required as an FQHC to participate in the Uniform Data System reporting program to HRSA.

E-Prescribing

E-Prescriptions, E-Rx or Electronic Prescriptions are computer-generated prescriptions created by your provider and sent directly to your pharmacy. HOPE participates in E-prescribing because we care about your health and well-being and E-prescribing has multiple benefits. By consenting, HOPE can also access a history of my current and past prescriptions. This critical information assists HOPE in confirming the safety of my prescriptions and minimizing dangerous interactions with my other medications.

Patient Information Documents

Communications

I understand that my email address and other contact information that I have provided will be used by HOPE for various purposes including, but not limited to, appointment reminders, prescription medication refill reminders, and registration for HOPE's patient portal. HOPE's secure patient portal allows patients to communicate with their health care providers and access some information in their medical records such as medication lists, certain laboratory results, and immunization records, however, these features may change from time to time. I understand that my email address will be used by HOPE to create a secure portal account for me, but that I will be required to establish my login information in order to access the portal.

Greater Houston Healthconnect

HOPE participates in Health connect; a non-profit organization that provides a secure electronic network for Health connect participants. A list of current Health connect participants is available at www.ghhconnect.org. HOPE's participation with others in Health connect, such as labs, pharmacies, radiology centers, doctors' offices, hospitals, and health insurers, permits HOPE to access, and utilize in providing care to you, any available electronic health information related to you.

All Health connect participants must protect your privacy in accordance with state and federal laws. Your treatment and eligibility for benefits will not be affected. By my signature below, I agree that Health connect and its current and future participants, including HOPE, may use and disclose my protected health information electronically for the limited purposes of treatment, payment and health care operations. I understand that Health connects may connect to other health information exchanges in Texas and across the country that also must protect my protected health information in accordance with state and federal laws, and I authorize Health connect to share my information with those exchanges for the same limited purposes of treatment, payment and health care operations. This authorization remains in effect unless and until I revoke it. I understand that I can revoke this authorization at any time by giving written notice to any healthcare provider who participates in Health connect and my revocation will be effective within three (3) days. I also understand that revoking this authorization does not affect information previously shared when my authorization was in effect. HOPE also participates in other secure records transfer and health information exchange programs including but not limited to Care Equality and Common well. If you choose not to participate in programs, you should notify the HOPE Clinic Quality Improvement Office in writing by emailing comments@hopechc.org or providing a written statement in person to the HOPE Clinic Privacy Officer.

Important Information You Need to Know about Telehealth/Telemedicine at HOPE

Limitations of Telemedicine/Telehealth

As a HOPE patient receiving services via telemedicine/telehealth, your provider is required to provide notice (an explanation) regarding telemedicine/telehealth services, including the risks and benefits of being treated via telemedicine/telehealth, how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure.

Necessity of In-Person Evaluation

As a HOPE patient receiving services via telemedicine/telehealth, your provider is required to inform you before the conclusion of the encounter, if he or she is unable to provide all pertinent clinical information that a health care provider exercising ordinary skill and care would deem reasonably necessary for the practice of medicine or health services at an acceptable level of safety and quality in the context of that particular medical encounter. If that occurs, your provider is required to advise you to obtain additional medical evaluation reasonably able to meet your needs.

Rights and Responsibilities. Recording Telemedicine Appointments

I understand that by agreeing to participate in HOPE's telemedicine/telehealth services, I will not audio and/or audio/video record HOPE workforce members without their express permission obtained in advance of any recording. A violation of this recording limitation may result in HOPE requesting that I destroy the recording, including any postings of the materials that have been shared and may also result in HOPE discontinuing telemedicine/telehealth services to me.

Complaints to the Board

As a HOPE patient receiving services, if you wish to file a grievance or complaint with the Texas Board of Medicine or HOPE's Risk Manager, please contact HOPE at comments@hopechc.org or call 713-773-0803 ext. 277. You will not be penalized for filing a complaint.

Terms of Consent

I understand my consent is necessary for HOPE to offer services to me and that some items may not apply to my current situation. I also understand that, in order to provide comprehensive care during this and future visits, and to evaluate my eligibility for programs, my signature below indicating my agreement to this document in its entirety, is required. By signing this form, I acknowledge and agree to the terms, information and obligations contained in this document. I am giving this consent of my own free will. I have had the opportunity to read and ask any questions about the information in this packet, specifically including, but not limited to, the financial obligations provisions and assignment of benefit provisions.

I acknowledge that I either have no questions or that my questions have been answered to my satisfaction in a language I understand. I sign this document freely and agree to abide by its terms. I understand that this document remains in effect until I revoke my consent, at any time, in writing. I also understand that revoking this authorization does not affect any actions previously taken based on this consent.

By signing this form, I attest that all the statements I have made, including my answers to all questions, are true and correct to
the best of my knowledge and belief. I agree to give the HOPE eligibility staff any information necessary to confirm statements
about my eligibility. I understand that giving false information could result in eligibility disqualification and a possible repayment obligation. I also agree to inform the eligibility staff should my income or number of people in my family change.

Patient Name/Nombre del Paciente	Date/Fecha	Signature/Firma

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