Petaluma Health Center

**PATIENT REGISTRATION (COMPLETE BOTH SIDES)**

| **PATIENT INFORMATION (please fill out in blue or black pen)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Today's Date | | Last Name | | First | | M.I. | |
| Date of Birth | | Social Security No. | - - | | | | |
| Street Address | | | | Apartment/Unit# | | | |
| Mailing Address | | | | | | | |
| City | | | State | | ZIP Code | | |
| Home Phone | | Work Phone | | Cell Phone | | | |
| May we leave phone messages for you? ☐ Yes ☐ No **If Y -Please Circle The Best Number Above To Contact You** | | | | | | | |
| Email address for use in PHC Patient Portal ☐ Yes ☐ No<br>Is it OK to e-mail information? ☐ Yes ☐ No | | | Email | | | | |
| Parent or Guardian Name | | | Relationship? | | | | |
| Custodial Responsibility | ☐ Joint ☐ Sole ☐ Other *(please explain)* _____ | | | | | | |
| Gender at Birth | | Current Gender | | Sexual Orientation | | | |
| Race *(Please check all apply)* | ☐ African American/Black ☐ Alaskan Native ☐ American Indian: Tribal Affiliation_____<br>☐ Asian ☐ Caucasian/White ☐ Pacific Islander ☐ Native Hawaiian ☐ Refuse to provide | | | | | | |
| Ethnicity | ☐ Latino ☐ Hispanic ☐ Not Latino/Hispanic Spoken/Written Language?<br>☐ Refuse to report ☐ More than one race | | | | | | |
| Marital Status | ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed | | | | | | |
| Housing Status | ☐ Not Homeless ☐ Doubling up<br>☐ Street/Camp ☐ Homeless Shelter | Have you been homeless since January of this year?<br>☐ Yes ☐ No Date: _____ | | | | | |
| Military Status | ☐ Active Duty Military ☐ Retired Military ☐ Veteran | | | | | | |
| Employment Status | ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ FT Student<br>Student, what school do you attend?_____ ☐ PT Student | | | | | | |
| If employed in agriculture: ☐ Migrant ☐ Seasonal ☐ Employed Year Round | | | | | | | |
| Employer | | | Occupation | | | | |
| Preferred Pharmacy | | | | | | | |

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| EMERGENCY CONTACT | | | | | |
|---|---|---|---|---|---|
| Name | | Relationship | | | |
| Home Number | | Cell Number | | City/State | |

| CURRENT HEALTHCARE PROVIDER | | |
|---|---|---|
| Do you have a previous Medical Care Provider? | ☐ Yes ☐ No | *If Yes – please list:* |
| Do you have a Dentist? | ☐ Yes ☐ No | *If Yes – please list:* |

**PRIMARY INSURANCE** *(you will be asked to show your card at the appointment)*

Name of Policy Holder _____

Insurance Company Name _____ Policy Start Date _____

Policy/ID Number _____ Group/Plan Number _____

Claims Address _____

City _____ State _____ Zip_____

**SECONDARY INSURANCE – if appropriate** *(you will be asked to show your card at the appointment)*

Name of Policy Holder _____

Insurance Company Name _____ Policy Start Date _____

Policy/ID Number _____ Group/Plan Number _____

Claims Address _____

City _____ State _____ Zip_____

PHC is dedicated to ensuring you have access to our services and our staff is available to assist you in determining if you are eligible for a variety of health benefit coverage options. Noone is denied care due to inability to pay. These options may include ability to pay based on sliding fee discounts, special grant-provided services or public-funded health care coverage such as Medi-Cal. In many cases, our staff can assist qualifying patients with the enrollment or assessment process. PHC offers discounted fees for qualified patients who may be unable to pay the full fee for services. As a non-profit organization, we receive funding from local, state, federal and grant funding sources and we are required to collect financial information from our patients to continue to receive this funding. All information will remain confidential. By declining to provide the requested financial information, you will be ineligible for financial assistance for your care.

| | | | | | |
|---|---|---|---|---|---|
| Approximate Total Annual Household Income | $ | # of individuals in the home | | Number of individuals under the age of 18 the patient is responsible for | |
| **FOR OFFICE USE ONLY** | Date Entered | | Staff Initials | | |

**PATIENT CONSENT AND AUTHORIZATION FORM FOR DISCLOSURE OF HEALTH INFORMATION BY PHC**

Petaluma Health Center

| Last Name | | First | | Date of Birth | |
|---|---|---|---|---|---|

Petaluma Health Center takes the privacy of your health information very seriously. As a courtesy to you, we bill your insurance company and must share certain information with the insurer in order to process claims.

**MEDI-CAL PATIENTS**

The Qualified Service Organizations (QSO) listed below contract with the State of California to provide health care services to Medi-Cal members. Medi-Cal may assign you to one of the QSOs for the management of your services. The QSOs process claims for services submitted by PHC. The QSOs are also required to submit information on all claims paid or processed to California Medi-Cal for administration purposes.

I authorize PHC to disclose my health information, including information related to my treatment for alcohol and/or drug abuse, to one of the QSOs listed below to which I have been assigned for the purpose of submitting claims for payment to the QSO and to other organizations for continuity of care.

- Beacon Health
- Medical Consultants
- Hospitals
- Partnership Health Plan

**ALL OTHER INSURANCE PLANS**

I hereby authorize PHC to disclose my health information, to consulting medical providers, hospitals, and other specialists for the purpose of claims processing. This may include releasing certain information related to my treatment for alcohol and/or drug abuse to my insurance payer for the purpose of submitting claims for payment.

**I consent to share:**

- My treatment may not be conditioned if I do not sign this form.
- I have received a copy of this signed document.
- I understand that I may revoke this authorization at any time by giving written notice to PHC, except to the extent that PHC or the QSO has already acted on it.
- This authorization will expire on the date that I am no longer a California Medi-Cal member, a member of my health plan or two years from the date of my signature, whichever is earlier.

| Signature of Patient or Legal Representative | | Date | |
|---|---|---|---|
| Print Name of Legal Representative (if applicable) | | Relationship to Patient | |
| **Revocation: I revoke my authorization for disclosure of SUD information to my payer(s).** | | | |
| Signature of Patient or Legal Representative | | Date | |

## CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Petaluma Health Center

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ **(Patient initials)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

| | |
|---|---|
| Cell Phone Number | (  )  - |

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/information in the Patient Portal to the following Email Address:

_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

| | | | | | |
|---|---|---|---|---|---|
| Signature | | Name (please print) | | Date | |

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## CONSENT FOR INTEGRATED EVALUATION AND TREATMENT

| Last Name | | First | | Date of Birth | |
|---|---|---|---|---|---|

I hereby consent to treatment, including tests, procedures and medications, as directed by PHC staff and have been given enough information to make an informed decision. Furthermore, I understand my treatment will have a greater chance of success when I participate in its design and fully cooperate with any professional recommendations that are provided to me. I also understand that I may cancel this consent at any time, in writing. In order to provide the highest quality care i authorize PHC to review my prescription history from other providers such as hospitals, specialists, etc.

| Patient or Legal Guardian Signature | | Date | |
|---|---|---|---|
| Patient name (please print) | | | |
| Legal Guardian name (please print) | | | |

### PLEASE NOTE THE FOLLOWING WITH REGARD TO TREATMENT

PHC staff will depend on statements made by the patient, information provided in patient's medical history and other information as available to evaluate a patient's condition and decide on the best treatment.

Some services at PHC may be provided with telemedicine equipment and involve interaction with providers who are not physically in the clinic for your appointment. These sessions are transmitted via secure, dedicated high-speed lines and are not: videotaped, routed through the Internet, or saved in any way. However, relevant information from your visit will be documented in your medical records, just as it would be if the provider had been physically present.

Your healthcare providers will discuss with you the benefits and risks of treatment. If you are unclear about your treatment or the protection of your records, please feel free to ask questions at any time.

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## FINANCIAL AGREEMENT (PLEASE COMPLETE BOTH PAGES)

| Last Name | | First | | Date of Birth | |
|---|---|---|---|---|---|

We are dedicated to providing you with the best care possible and partnering with you to ensure the care is accessible. In order to support both of these goals, patient financial responsibility is detailed in this agreement. Below are the PHC policies regarding collection of information, insurance billing and financial responsibility.

### INFORMATION SECURITY

We recognize that many patients are concerned about the sensitive nature of the information we collect. Please be assured that we take every precaution to keep your personal information secure and use this information only to assist us in providing the services, filing claims and for identification/communication purposes as it relates to healthcare operations. We are required to obtain complete demographic information which includes your social security number to support billing for the services.

### PATIENTS WITH INSURANCE

It is your responsibility to understand the benefits and limitations of your insurance coverage. PHC maintains contracts with most major insurance plans, accepts assignment of your insurance benefits, and in many cases, will file your insurance claim for you. Insurance co-payments are due at time of service. If applicable, co-insurance and/or deductibles will be billed to you at a later date once insurance processes the claim.

**Assignment of Benefits**

By signing this document, I hereby assign all medical benefits for which I am entitled to at PHC. Furthermore, my signature authorizes and directs my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment directly to PHC for services rendered. I understand that I am responsible for any amounts not covered by my insurance.

**Release of Information**

I authorize PHC to release medical information necessary for the purpose of filing claims for payment with my insurance company.

If we do not have a contract with your insurance carrier, PHC will, as a courtesy, file the claim on your behalf but may not accept assignment on your claim. Under these circumstances, your insurance will pay you directly for these services. You in turn are responsible for payment to PHC and we request that you provide payment to us within 30 days of receiving your bill.

### SLIDING FEE DISCOUNT PROGRAM

**Petaluma Health Center's Sliding Fee Discount Program promotes access to care for low-income patients.**

- Income and family size are the only factors considered when determining your eligibility for the Sliding Fee Discount Program.
- Application for and denial of health insurance coverage is not a prerequisite for eligibility for the Sliding Fee Discount Program

**In order to help us to accurately determine your eligibility for the Sliding Fee Scale Program, as applicable, please bring all the below documents within 7 business days.**

- Proof of Income: 2-4 pay stubs, income tax forms, letter verifying income from employer, documents verifying other sources of income, such as unemployment and retirement benefits, SSI, alimony, child support etc.
- If you do not have your proof of income at your appointment, you may estimate your family's current gross annual income to determine your eligibility for the sliding fee discount program for a 7-day period. Please bring supporting documentation to the health center before the end of the 7-day period to allow us to make a final determination on your application. Failure to bring documentation will convert your status to "private pay," and you will not be eligible for the Sliding Fee Scale program until you bring income documentation.

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· If you are determined to be eligible for the Sliding Fee Scale Program, you will be enrolled in the program for a 12- month period. After 12 months, you must re-apply for the program.

· Certified Enrollment Counselors are available to help you determine if you are eligible subsidized health coverage programs, such as Medi-Cal, CMSP, Covered California or other subsidized health coverage programs. If you are interested in determining your eligibility for these programs, please let a front desk staff member know so they can schedule an appointment. Applying and being denied for health coverage is NOT a prerequisite for enrolling in the Sliding Fee Scale Discount Program.

| Last Name | | First | | Date of Birth | |
|---|---|---|---|---|---|

## STATEMENTS

As a courtesy, PHC will send statements each month for any outstanding balance you owe for services. Due to the separate billing systems required for the variety of services provided in our center, you may receive separate statements for different types of services rendered in our clinics.

## FINANCIAL RESPONSIBILITY

You are responsible for any balance due regardless of insurance coverage. In the event that any account becomes past due PHC reserves the right to collect on these balances prior to scheduling any future appointments.

## AGREEMENT TO PAY

By signing below you acknowledge your responsibility to pay for any services rendered by PHC. You also acknowledge your understanding that you may be billed for multiple services on the same day if you received both behavioral health and primary care services.

For your convenience we accept cash, check, or credit card as payment.

## ACKNOWLEDGMENT

I have received, understand and agree to abide by the above as it relates to my financial obligations as a patient.

| Patient or Legal Guardian Signature | | Date | |
|---|---|---|---|
| Patient name (please print) | | | |
| Legal Guardian name (please print) | | | |

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## ACKNOWLEDGMENT OF INFORMATION RECEIVED

| Last Name | | First | | Date of Birth | |
|---|---|---|---|---|---|

### PHC WRITTEN ACKNOWLEDGMENT OF AVAILABILITY OF NOTICE PRIVACY PRACTICES & NOTICE OF ELECTRONIC HEALTH INFORMATION EXCHANGE NOTIFICATION

### ELECTRONIC HEALTH INFORMATION EXCHANGE NOTICE

PHC endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share (when appropriate) clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps all of your health care providers more effectively share information and provide you with better care. The HIE network through the Redwood Community Health Coalition also enables emergency medical personnel and other providers who are treating you to have immediate access to the available medical data about you that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. Information regarding drug and alcohol treatment is unavailable except in emergencies. However, you may choose to opt-out of participation in the PHC HIE, or cancel an opt-out choice at any time.

### NOTICE OF PRIVACY PRACTICE

PHC adheres to all state and federal regulations as they apply to the access, protection, disclosure and use of your healthcare information contained in our records. The PHC Notice of Privacy Practices provides you with the details associated with how PHC will manage this protected information about you and is available by asking for a printed copy at any of our clinic locations. I also understand that details regarding the privacy protections for my record is contained in PHC's Notice of Privacy Practice are available to me.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise stated in the regulation. I also understand I can revoke this consent at any time except to the extent that action has been taken in reliance on it.

The following information is also available to you. It can be requested at any of the clinic locations.

**Appointment Policy**
**Notice of Privacy Practices**
**Medical Grievance Policy**
**Patient Rights & Responsibilities**
**Advance Directives**

Our staff is available to assist you in this process if needed. Please note, by signing, you are confirming that you have read or have access to the documents above.

| Signature of Patient or Legal Guardian | | Date | |
|---|---|---|---|
| Patient name (please print) | | | |
| Legal Guardian name (please print) | | | |