Hurtt Family Health Clinic
1 Hope Drive Tustin, CA 92782
Clinic: (714) 247-0300 Fax: (714) 259-1598
www.hurttclinic.org

REGISTRATION PACKET

Dear Patient: We are a non-profit clinic that provides low cost health care on a sliding scale. Visit costs for patients are determined by a sliding fee scale that is calculated based on income and household size. This practice serves all patients regardless of inability to pay. Due to new federal reporting regulations, the following information is now required for each patient. Please note that all information is confidential. We appreciate your cooperation with these new reporting requirements and will need to collect this information on an annual basis.

Patient Information:

Today's Date: _____

Last Name:

First Name: **MI:** **Date of Birth:**

Address: **City:** **Zip Code:**

Home Phone: **Cell Phone:**

Email Address: **SSN:** **Birth Sex:** ☐ Male ☐ Female

Living Arrangements: (please check one)

☐ **Shelter** (safe havens, temporary overnight housing, armories) ☐ **Transitional** (center, community, home) ☐ **Other** (hotel, motel, day-to-day single room occupancy)	☐ **Doubling Up** (living with other people for a temporary period and move often) ☐ **Street** (sidewalk, car, park, doorway, public or abandoned building)	☐ **Permanent Residence** (own, rent apartment/room/house)

Ethnic Origin: (please check one) **Hispanic**: ☐Yes ☐No

Race: (please check all that apply)

☐Caucasian ☐Asian ☐Pacific Islander ☐Native Hawaiian

☐Black or African American ☐American Indian/Alaskan Native ☐Other/Choose Not to Disclose

Gender Identity:

☐Male ☐Transgender Male/Female-to-Male ☐Other: _____

☐Female ☐Transgender Female/Male-to-Female ☐Choose Not to Disclose

Sexual Orientation:

☐Straight ☐Bisexual ☐Don't know

☐Lesbian or Gay ☐Other: _____ ☐Choose Not to Disclose

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

For office use only.
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Patient's Account #: _____

Spouse or Parent/Guardian Information (if applicable)**:**

Last Name: _____ First Name: _____ DOB: _____

Work Phone: _____ Cell Phone: _____

Primary Language: _____

Health Insurance: (please check) ☐Medicare ☐Medi-Cal ☐None

☐Other_____

Emergency Contact:

Last Name: **First Name:**

Relation to Patient: **Phone Number:**

In case of an emergency, Hurtt Family Health Clinic will provide your medical records to a hospital or other medical institution if you are unable to make medical decisions on your own behalf.
If you wish **not** to have your medical records sent on your behalf, please check this box:

☐In case of an emergency, I do **not** want my medical records sent on my behalf.

Current Symptoms: Please check any symptoms you have now. If none, check here: □ None

General
- □ Fatigue
- □ Fever
- □ Night sweats
- □ Loss of appetite
- □ Unexpected weight loss or gain

Blood/Lymph
- □ Anemia
- □ Swollen glands

Bones, Joints, Muscles
- □ Back pain
- □ Muscle aches
- □ Neck pain
- □ Swollen, red, or painful joints

Head, Eyes, Nose, and Throat
- □ Ear pain
- □ Eye pain
- □ Headaches
- □ Hearing loss
- □ Hoarseness
- □ Nose bleeds
- □ Ringing in your ears
- □ Sinus problems
- □ Sores or irritation in mouth or throat
- □ Teeth or gum problems
- □ Vision problems

Heart and Circulation
- □ Chest pain or pressure
- □ Fast or irregular heartbeat
- □ Pain in legs with walking
- □ Swelling of feet or ankles

Lungs
- □ Coughing up blood
- □ Shortness of breath at rest
- □ Trouble breathing while lying down
- □ Unexpected shortness of breath during activity
- □ Wheezing

Mental Health
- □ Anxiety
- □ Depression
- □ Extreme worry
- □ Trouble sleeping
- □ Trouble thinking or concentrating

Nervous System
- □ Trouble with walking
- □ Trouble with coordination
- □ Dizziness
- □ Fainting or black-out spells
- □ Memory problems
- □ Numbness
- □ Seizures
- □ Shaking
- □ Speech problems
- □ Tingling
- □ Tremor
- □ Weakness

Skin
- □ Bleeding or bruising from minor injury
- □ Changes in hair or nails
- □ Changes in moles
- □ Dryness
- □ Itching
- □ Rashes

Stomach and Intestines
- □ Abdominal pain
- □ Black stools
- □ Bloating
- □ Blood in stool
- □ Bowel habit change
- □ Constipation
- □ Diarrhea
- □ Difficulty or pain with swallowing
- □ Heartburn or indigestion
- □ Nausea
- □ Rectal pain
- □ Vomiting

Urination
- □ Frequent daytime urination (more than 6 times/day)
- □ Trouble holding urine or incontinence
- □ Pain or burning
- □ Trouble starting or stopping urine
- □ Waking to urinate more than 1 time/night

Reproductive

Females:
- □ Bleeding or spotting between periods
- □ Heavy or painful periods
- □ Irregular periods
- □ Vaginal discharge

Males:
- □ Prostate problems
- □ Scrotal pain or swelling

Other
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____

Current and Past Health Conditions: Have you ever had any of the following?
Please check box to indicate yes. If none, check here: □ None

Bones and Joints	Now	Past
Arthritis	□	□
Fracture or broken bone	□	□
Osteoporosis or thinning of the bones	□	□
Head, Ears, Eyes, Nose, and Throat	Now	Past
Cataracts or glaucoma	□	□
Other vision problems	□	□
Hearing problems	□	□
Heart and Circulation	Now	Past
Anemia	□	□
Bleeding problems	□	□
Blood clot	□	□
Blood transfusion	□	□
Chest pain	□	□
Heart attack	□	□
Heart failure	□	□
Heart murmur	□	□
Heart rhythm problems	□	□
High blood pressure	□	□
Kidneys and Bladder	Now	Past
Genital problems	□	□
Kidney failure	□	□
Kidney stones	□	□
Other kidney or bladder problems	□	□
Urinary tract infection	□	□

Lungs	Now	Past
Asthma	□	□
Emphysema, chronic lung disease	□	□
Pneumonia	□	□
Nervous System and Behavior	Now	Past
Depression	□	□
Head injury, concussion	□	□
Other mental problems	□	□
Seizures or epilepsy	□	□
Stroke	□	□
Skin	Now	Past
Skin disease	□	□
Stomach and Intestine	Now	Past
Gallbladder problems	□	□
Hepatitis, other liver disease	□	□
Stomach ulcers	□	□
Other	Now	Past
Abnormal blood sugar	□	□
AIDS or positive HIV test	□	□
Cancer	□	□
Diabetes (including in pregnancy)	□	□
Thyroid gland problem or goiter	□	□
Transplant (List type):_____	□	□
Tuberculosis or positive TB test	□	□
Other (Explain):_____	□	□

Depression Screening:

1. Over the past month, have you felt down, depressed, or hopeless? ☐Yes ☐No
2. Over the past month, have you felt little interest or pleasure in doing things? ☐Yes ☐No

Statement of Present Health:

1. Please check the box that best represents your present health:
   ☐Excellent ☐Good ☐Fair ☐Poor

2. Do you take any prescription drugs routinely? ☐Yes ☐No
   If yes, please explain: _____

3. Do you take any non-prescription drugs, herbs, or supplements routinely? ☐ Yes ☐ No
   If yes, please explain: _____

4. Do you have any medication, food, or environmental allergies? ☐Yes ☐No
   If yes, please explain: _____

5. Do you exercise regularly? ☐Yes ☐No
   If yes, how often: _____

6. Are you currently experiencing any oral pain? ☐Yes ☐No
   If yes, please explain: _____

7. Have you ever been hospitalized? ☐Yes ☐No
   If yes, please explain: _____

8. Have you ever had surgery? ☐Yes ☐No
   If yes, please explain: _____

9. Do you smoke, drink, or use recreational drugs? ☐Yes ☐No
   If yes, please explain how much and how often of each:
   _____
   _____

10. Date of most recent physical exam: _____
11. Date of most recent tetanus shot: _____
12. Date of most recent colonoscopy: _____
13. Date of most recent pap smear: _____
14. Date of most recent TB test: _____
15. Date of most recent mammogram: _____
16. Date of most recent dental visit: _____

Family History: Has anyone in your immediate family ever had any of the following? Please check all that apply. If none, check here: □ None

☐Alcoholism	☐Diabetes	☐HIV/AIDS	☐Stomach/Intestine problems
☐Anemia	☐Depression	☐Kidney disease	☐Stroke
☐Anxiety	☐High blood pressure	☐Lung disease	☐Suicide
☐Cancer	☐Heart disease	☐Migraines	☐Thyroid disease
☐Convulsions	☐Hepatitis	☐Mental disorders	☐Tuberculosis

Immunizations: Please check if you have had any of the following immunizations:

☐BCG (Tuberculosis vaccine)

☐Chicken Pox (Varicella)

☐Cholera

☐Diphtheria

☐Hepatitis A

☐Hepatitis B

If yes, was a series of 3 injections completed? ☐Yes ☐No

☐Malaria

☐Measles, Mumps, Rubella

☐Pneumonia

☐Smallpox

☐Tetanus

☐Typhoid

☐Typhus

☐Yellow fever

☐Other: _____

It is the policy of Hurtt Family Health Clinic to test for HIV, unless you choose not to be tested. If you wish **not** to be tested, please check this box:

☐I do not want to be tested for HIV

Gynecologic History: *(Men continue to "Sexual History")*

1. Do you still menstruate? ☐Yes ☐No
   If no, please explain: _____
2. If you have had a hysterectomy, were your ovaries removed? ☐Yes ☐No ☐Don't know
3. How many pregnancies have you had? _____
4. How many children have you given birth to? _____
5. Are you currently pregnant or trying to get pregnant? ☐Yes ☐No ☐Don't know

Sexual History:

1. What is your current method of birth control?
   ☐I am not sexually active ☐Same sex partner ☐I am post-menopausal ☐No birth control
   ☐Other _____
2. Have you ever had any of the following sexually transmitted diseases?
   ☐Chlamydia ☐Syphilis ☐Trichomonas ☐PID/Pelvic infection ☐Don't know
   ☐Gonorrhea ☐Herpes ☐Genital warts ☐None

*** OPTIONAL: Lifestyle and Health:**

1. Over the past year, how often did you skip a meal or eat less than you know you should because there was not enough food or money to buy to food?

   ☐Never ☐Monthly ☐Daily or almost daily ☐Less than monthly ☐Weekly

2. Do you have any trouble taking care of your daily activities (buying food, arranging transportation)?
   ☐Yes ☐No
   If yes, please explain: _____

3. Are you under any specific stresses? ☐Yes ☐No
   If yes, please explain: _____

4. Is your medical care likely to be a financial burden for you? ☐Yes ☐No

*** OPTIONAL: Health Education:**

1. Would you like any written information on a health-related topic? ☐Yes ☐No
   If yes, which topic: _____
2. How do you like to learn?
   ☐Seeing (pictures/videos)
   ☐Hearing (listening to people, audiotape)
   ☐Doing (hands-on)
3. Do you have any values or beliefs that we should consider when planning your care? (e.g. cultural or religious) ☐Yes ☐No

   If yes, please explain: _____

   _____

   _____

I have received, read, and agreed to the attached terms and conditions of the Registration Packet and acknowledge that I have filled out the included information to the best of my abilities.

Registration Packet includes the following documents:

- **Authorization for Treatment**
- **HIPAA Notice of Privacy**
- **Patient Bill of Rights**
- **Patient's Responsibilities**
- **Additional Consents**
- **Dental Facts**
- **Advance Directive**

Signature (Patient or Authorized Person)	**Date**	**Relationship, if not patient**

SLIDING FEE APPLICATION

Date: _____

Last Name: _____ First Name: _____

Date of Birth:_____ Social Security Number: _____

Please check this box and sign this application if you do not wish to be screened for the Sliding Fee Discount Program and are voluntarily choosing to **decline** the Sliding Fee Discount Program. By checking this box, you understand that in the event that a rendered service is not covered by your insurance, you will be responsible to pay the full fee associated with you visit.

☐ *I decline the Sliding Fee Scale Discount Program and agree to the statement above.*

This application requires the patient to report their household size and income. To complete your application, please provide your Patient Service representative with the following supporting documentation:

Government issued identification card of the head of the household; Accepted forms of ID include:

- ☐ CA driver license or ID
- ☐ Consular ID card (CID)
- ☐ Passport

Proof of address with the name/address of the head of household; Accepted forms of proof of address include:

- ☐ Electricity bill
- ☐ Home phone bill
- ☐ Car registration or car insurance
- ☐ Rent receipt
- ☐ Lease agreement

Proof of income to calculate gross annual income. Accepted forms of income verification include:

- ☐ Paystubs
- ☐ Federal/State Income Tax Form
- ☐ Wages and Tax Statement (e.g. W-2)
- ☐ Foreign Income
- ☐ Self-employment ledger documentation
- ☐ Bank Statement
- ☐ Self-Declaration Form
- ☐ Employer Statement (signed by employer)

Total Number of People in Household:_____

Total household includes any immediate family members living in the home (i.e. mother/father/children) and any person that lives in the home and mutually contributes to household expenses.

Total Annual Income: $_____

Total income includes employment wages, social security benefits, unemployment benefits, disability benefits, alimony/child support, and pension.

Signature: _____ Date: _____

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information (PHI) be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must provide an alternative address or other method of contacting you. ***Some method of contact must be provided***.

Hurtt Family Health Clinic will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

Hurtt Family Health Clinic also utilizes 3rd party entities to disclose certain PHI, including 3rd party medical record coordination, health information exchanges (HIE) with local hospitals and medical providers, and the patient portal.

This request supersedes any prior request for communication of information submitted prior to the date below.

Extended Authorization

Please list any persons you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker or other family member:

Name (First and Last)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Restrictions on Communication Methods

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below any ways in which you do NOT want to receive communications:

□ No calls to phone number(s): _____
□ No messages or voice mails left on phone number(s): _____
□ No mail to the following address: _____
□ 3rd Party Medical Record Coordination
□ Health Information Exchange (HIE)
□ Patient Portal
□ Other (please specify): _____

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (please print) Relationship to Patient

Medical Treatment Authorization (Minors)

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____ to consent to any x-ray,

(full name of an adult into whose care the minor has been entrusted)

examination, immunizations, anesthetic, all medical, dental, and mental health services, or surgical

diagnosis or treatment and hospital care of _____ deemed advisable

(full name of the minor)

by a license physician and surgeon and provided by that physician or under that physician's supervision,

regardless of where that treatment is provided.

This authorization is made under Family Code §6910.

This authorization supersedes any prior request for authorization to treat a minor submitted prior to the date below. It remains in effect until revoked in writing.

Signed: _____ Date: _____

Print Name: _____

Please specify relationship to minor:

□ Parent with legal custody

□ Guardian with legal custody

□ Other: _____

REQUIREMENTS TO REGISTER WITH THE CLINIC

- ✓ **Identification**
  Acceptable forms of ID include: Driver's License, California I.D., Passport, Green Card, School I.D., etc.
- ✓ **Your Insurance Card**
  There is NO FEE to register at the clinic. If you do not have any health/medical insurance coverage, please be prepared to pay by cash or check for each visit with the provider and for all labs. If you have a co-pay, please be prepared to pay by cash, check, or credit for each visit with the provider and for all labs.

INFORMING MATERIALS:

For all patients of Hurtt Family Health Clinic:

- **Authorization for Treatment**
- **HIPAA Notice of Privacy**
- **Patient Bill of Rights**
- **Patient's Responsibilities**
- **Additional Consents**
- **Dental Facts**

AUTHORIZATION FOR TREATMENT

Medical care is a patient care service in response to a wide range of medical care needs of patients of all ages regardless of gender, color, race, creed, national origin or disability, five days a week. The Hurtt Family Health Clinic uses evidence-based practices to make decisions about treatment and in order to provide high quality healthcare for all patients.

The purpose of medical care is:

- To treat disease, injury and disability by examination, testing and use of procedures as needed, in the aid of diagnosis or treatment.
- To obtain information needed in diagnosing and examining patients.
- To prevent or minimize residual physical and mental disability.
- To aid patients in achieving their maximum potential within their capabilities.
- To accelerate convalescence and reduce the length of the functional recovery.

All procedures will be thoroughly explained to you before you are asked to perform them. You are expected to cooperate fully with the examination and stop any test or procedure before experiencing any increase in your current level of pain or discomfort. There are certain inherent risks with medical care; if you have any concerns about your proposed treatment as described by your provider please let them know prior to the examination or procedure. The attending physician or provider will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. Based on the above information, you agree to cooperate fully and to participate in all medical care procedures and to comply with the plan of care as it is established.

***Notice to Patients**
For your personal safety, do not use any equipment without a staff member present.

HIPAA NOTICE OF PRIVACY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and disclosures:

1. TREATMENT: We will use and disclose your information to provide, coordinate, or manage your health care and any related services. This could include the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. Another example includes providing information to a physician to who you have been referred to ensure correct information for your diagnosis.
2. PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your information be disclosed to the health plan to obtain approval for the hospital admission.
3. HEALTH CARE OPERATIONS: We may use or disclose, as needed your protected health information in order to support business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to indicate your physician. We may also call you by name in the waiting room and call you to remind you of your appointment.
4. We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal and military activity, national security, workers compensation, inmates. Required use and disclosures; under law, we must make disclosures to you and when required by the Secretary of the Department of Health & Human Services to investigate or determine our compliance with requirements of Section 164.500.
5. Other permitted and required uses and disclosures will ONLY be made with your written consent, authorization, or opportunity to object unless REQUIRED by LAW. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

I hereby consent to the use and disclosure of all medical data about me or my minor children for uses allowed by law, including for the following purposes:

1. Review by doctors, hospitals, other health care providers and their staff who treat us.
2. Review by insurers, administrators, and others who may pay for the cost of treating us.
3. Review by health care officials when statutes, regulations or professional duty so require.

PATIENT BILL OF RIGHTS

As a patient of Hurtt Family Health Clinic, you have the right, consistent with California law, to:

1. Understand and use these rights, if for any reason you need help with this, we will provide assistance.
2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or sexual orientation.
3. Receive considerate and respectful care in a clean and safe environment.
4. Be informed of the name and position of the health care provider who will be in charge of your care.
5. Know the name, position, and function of any staff involved in your care and refuse treatment, examination, or observation by that person.
6. Receive care in a non-smoking environment.
7. Privacy and confidentiality of all information and records regarding your care.
8. Participate in all decisions about your treatment.
9. Refuse treatment, examination or observation and be told what effect this may have on your health.
10. Obtain a copy of your medical records within a reasonable period of time
11. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
12. Receive all the information you need to give informed consent for any proposed procedure treatment. This information shall include the possible risks and benefits of the procedure or treatment.
13. Receive urgent care if you need it.
14. Complain, without fear of reprisals, about the care and services you are receiving and to have Hurtt Family Health Clinic respond to you, and if you request it, provide you with a written response. If you are not satisfied with the response, Hurtt Family Health Clinic must provide you with the telephone numbers of alternate physicians so that you may transfer your medical care.

PATIENT'S RESPONSIBILITIES

The staff at Hurtt Family Health Clinic strives to provide you, the patient, with the best care possible. Below are some things you can do to help us achieve that goal:

1. Arrive on time for scheduled appointments. If you will not be able to make the appointment please call 24 hours in advance to cancel and reschedule. If you arrive after your scheduled appointment, you may be asked to wait for the next available appointment or to reschedule.
2. Give your health care provider all the information that is needed to determine the best treatment for you; fill out forms completely and accurately.
3. Provide correct and complete contact information.
4. Be open and honest with your health care provider.
5. Call your health care provider promptly if your condition worsens or does not follow the expected course
6. Check with your provider well before you run out of your current supply of medication.
7. Use prescription and over the counter medications as directed. You should never share medication prescribed for you with others.
8. Treat fellow patients at Hurtt Family Health Clinic with the same courtesy and respect that you would expect from them. Please respect others right to privacy as you would ask that your own be respected.
9. Arrive to your appointment sober and prepared. If you arrive or present as under the influence of any illicit substances, you may be asked to leave and reschedule your appointment for another day.

ADDITIONAL CONSENTS

APPLICABLE LEGAL DOCUMENTS FOR MINORS

For all minor patients (under 18 years of age), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. Applicable legal documents pertaining to custody, divorce, separation, adoption or name change of a parent or child are required.

*All minors must have a birth certificate on file before being seen by a provider. *

LIMITED CONSERVATORSHIP

Limited conservatorships are for adults with developmental disabilities who are unable to make medical decision on their own behalf. If a patient is unable to make medical decisions on their own behalf due to a developmental disability, legal documentation appointing the conservator will be required. Proof of conservatorship must be presented at time of registration and before the patient can be seen by a provider. Documentation must include the right of the conservator to consent for medical treatment on behalf of the patient.

ADVANCE HEALTH CARE DIRECTIVE (AHCD)

An AHCD is a way to make your healthcare wishes known if you are unable to speak for yourself or prefer someone else to speak for you. An AHCD can serve one or both of these functions:

- Power of Attorney for Health Care (to appoint an agent)
- Instructions for Health Care (to indicate your wishes)

If you wish to complete an AHCD or would like additional information, please let you Patient Services representative know and you will be provided with an AHCD packet and FAQ sheet.

If you currently have an AHCD, please provide a copy for your medical records as soon as possible.