HURTT familyhealth CLINIC

Annual Update Form

Account Number: _____

Dear Patient: Due to new federal reporting regulations, the following information is now required for each patient. Please note that all information is confidential. We will need to collect this information on an annual basis.

Patient Information

Last Name	First Name	MI	Date of Birth

Address	Apt./Unit	City	State	Zip Code

SSN	Sex	Email Address
	☐ Male ☐ Female	

Please check primary phone ☐ **Home Phone** ( ) ☐ **Cell Phone** ( ) ☐ **Work Phone** ( )

Primary Language: ☐ English ☐ Spanish ☐ Other: _____ **Do you need an interpreter:** ☐ Yes ☐ No

Race (Please check all that apply): ☐ Asian Indian ☐ Filipino ☐ Other Asian ☐ Other Pacific Islander ☐ Black/African American ☐ White ☐ Chinese ☐ Japanese ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ American Indian/Alaskan Native ☐ Chose Not to Disclose Race ☐ Korean ☐ Vietnamese ☐ Samoan

Ethnicity: ☐ Mexican ☐ Chicano ☐ Cuban ☐ Non-Hispanic/Latino ☐Mexican American ☐ Puerto Rican ☐ Hispanic/Latino ☐ Decline to Specify

Birth Sex: ☐ Male ☐ Female

Sexual Orientation:
☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Don't know ☐ Chose Not to Disclose ☐ Other: _____

Gender Identity: *(How do you identify yourself?)* ☐ Male ☐ Female ☐ Female-to-Male/Transgender Male/Trans Man ☐ Male-to-Female/Transgender Female/Trans Woman ☐ Genderqueer ☐ Choose Not to Disclose ☐Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Health Insurance: ☐ Medicare ☐ Medi-Cal ☐ None ☐ Other: _____

Do you have an Advanced Directive: ☐ Yes ☐ No

Are you a Veteran: ☐ Yes ☐ No

Are you an Agricultural Worker? ☐ Yes ☐No *If yes, please select a class of work* ☐ Migratory ☐ Seasonal

Are you Homeless: ☐ Yes ☐ No

If yes, please select a living arrangement (Check one):

☐ **Permanent Supportive Housing** (does not have time limits, rent)

☐ **Transitional** (center, community, home)

☐ **Doubling Up** (living with other people for a temporary period and move often)

☐ **Other** (hotel, motel, day-to-day single room occupancy)

☐ **Shelter** (safe havens, temporary overnight housing, armories)

☐ **Street** (sidewalk, car, park, doorway, public or abandoned building)

Are you an OCRM Student: ☐ Yes ☐ No *If yes, select one of the following programs:*

☐ Alumni Housing ☐ Hope Family Housing ☐ Pearl House (non-Hurtt) ☐ Sea Glass (Hope Harbor) ☐ Village of Hope ☐ Double R Ranch ☐ House of Hope ☐ Rip Tide (Hope Harbor) ☐ Strong Beginnings ☐ Tustin Veterans Outpost

Pharmacy

Preferred Pharmacy Name:	Pharmacy Address:

Spouse or Parent/Guardian Information: (If applicable)

Last Name	First Name	Date of Birth

Please check primary phone ☐ **Home Phone** ( ) ☐ **Cell Phone** ( ) ☐ **Work Phone** ( )

Emergency Contact:

Last Name	First Name	Relation to the Patient	Phone Number ( )

Authorization for Release of Medical Information and Assignment of Benefits

I hereby authorize the release of medical or any other information necessary to my insurance carrier(s), or agent thereof to satisfy claims processing. I also authorize payment of medical benefits to Hurtt Family Health Clinic for services provided. I am financially responsible for payment of services not covered by my insurance.

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 *Patient Bill of Rights* *Advance Directive*
HIPAA Notice of Privacy *Patient's Responsibilities* *Additional Consents*

Signature:	Relationship to patient, if not patient:	Date:

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Sliding Fee Application

Account Number: _____

We are a non-profit clinic that provides low cost health care on a sliding scale. Discounts are calculated based on family income and size. It is necessary for us to ask personal questions in order to determine if you qualify for a discount for your visits. If you choose to not complete this documentation you will not be eligible to receive any discount. This information is confidential.

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.*

Last Name	**First Name**	**Date of Birth**	**SSN**

Employer:	**Occupation:**

Total number of dependents in the Household: _____

Total dependents 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 gross income: $_____ ☐ Weekly (52) ☐ Bi-Monthly (24) ☐ Monthly (12) ☐ Yearly/Annual (1)

Include income from all dependents in the household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

If no income:

☐ My family has no wages or income. I am not working (receiving salary or wages for work), or receiving unemployment or disability benefits. My income is $0.

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

Government issued identification:

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

Proof of income:

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

I certify that the family size and income information shown above is correct. Copies of verifying income may be required before a discount is approved.

Name: _____

Signature: _____ Date: _____

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Permission to Relay Information

Account Number: _____

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.

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 third party entities to disclose certain PHI, including third 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 such as your spouse, caretaker or other family member. This excludes information that is protected under State and Federal law.

Last Name	**First Name**	**Relationship**	**Phone Number** ( )
Last Name	**First Name**	**Relationship**	**Phone Number** ( )
Last Name	**First Name**	**Relationship**	**Phone Number** ( )

If you do not wish to add any extended authorization, please check the box below:

☐ I (the patient) do not authorize to disclose information to anyone (this excludes information that is protected under State and Federal law).

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:	☐ No messages or voice mails left on phone number(s):
☐ No mail to the following address:	

☐ Health Information Exchange (HIE)	☐ 3rd Party Medical Record Coordination	☐ Patient Portal	☐ Other (specify):

_____ _____

Signature (patient/legal representative) Date

If signed by someone other than patient, indicate relationship: _____

Print name: _____

(Legal representative)

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____ to consent to any x-ray, examination,
(Full name of an adult into whose care the minor has been entrusted)

immunizations, anesthetic, medical, dental, and mental health services, or surgical diagnosis or treatment and

hospital care of _____ deemed advisable by a license physician and surgeon and
(Full name of the minor)

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.

_____ _____
Signature (patient/legal representative) Date

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(Patient/legal representative)