HURTT familyhealth CLINIC

Account Number: _____

Annual Update Form

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 for the current year (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:

HURTT familyhealth CLINIC

Sliding Fee Program Application

Account Number: _____

This area for office use only.
☐ Initial ☐ Annual Review
☐ Update/Reason for Update: ☐ Income ☐ Marital Status ☐ Address ☐ Family Size ☐ Work Status ☐ Insurance Coverage

Patient's Name:	**DOB:** (mm/dd/yyyy)	**Patient is eligible for Column** _____ **of Sliding Fee Scale Table which means he/she is responsible for** _____ **of clinic charges.**
Verified with (check one box below): ☐ **State Driver's License** ☐ **Passport** ☐ **SS Card** ☐ **VISA** ☐ **Green Card** ☐ **OTHER:** _____	**Birthplace:** (CITY/STATE/COUNTRY)	

Guardian's Name:	**Relationship to Patient:**

Address: (Check Method Verified by: ☐ State Issued Driver's License ☐ Utility Bill ☐ Lease/Rental Agreement)

Home Phone:	**Cell Phone:**

Number of PEOPLE living in your household? (Write only family members who are responsible for each other i.e. spouse, dependent children, and the parents of the children).

NAME:	**AGE:**	**SS #:**
NAME:	**AGE:**	**SS #:**
NAME:	**AGE:**	**SS #:**
NAME:	**AGE:**	**SS #:**

Patient's Gross Income: ☐ **Month** ☐ **Year**	**Spouse's Gross Income:** ☐ **Month** ☐ **Year**	**Total Household Gross Income:** ☐ **Month** ☐ **Year**

Source of Income: ☐ **Employment** ☐ **Self-Employed** ☐ **Unemployment** ☐ **Disability** ☐ **Social Security Benefits** **Supplemental Security Income** ☐ **Child Support** ☐ **Family Member or Friend Supporting Patient** ☐ **Other:** _____

What was used to verify income? ☐ **Pay Stubs** ☐ **Tax Forms** ☐ **Other (specify)**_____

☐ **I am unable to provide Proof of Income AND I certify that this is my HOUSEHOLD INCOME, to the best of my knowledge:**

By signing below, I acknowledge that the sliding fee scale program is not a health insurance but an internal program for our patients who do not have insurance and are not eligible for public health insurance.

Regarding discounts on services, I am aware of the following:

1) **Discounts for Medical and Prescription Health Services are based on household income. All supporting documents must first be provided in order for application to be considered.**
2) **Discounts will be applied to services rendered according to date application was received, provided all necessary documentation is included within 30 days from the date of the application.**
3) **In order to continue to remain on this program, I am aware that I must apply annually.**

☐ **I agree that all of the above information is true to the best of my knowledge. Giving false information or by not submitting supporting documents within 30 days of my visit to the health center will result in my application being dismissed.**

☐ **I decline to participate in the Sliding Fee Scale Program.**

Patient/Parent or Guardian Signature:	**Relationship to patient:**	**Date:**
Received by HFHC Staff:		**Date:**

HURTT familyhealth CLINIC

Account Number: _____

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.

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)

Medical Treatment Authorization (Minors)

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)