HURTT familyhealth CLINIC

Account Number: _____

Patient Registration 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** ☐ Male ☐ Female	**Email Address**

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)

Health Questionnaire

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):_____	☐	☐

HURTT familyhealth CLINIC

Account Number: _____

Health Questionnaire

Please complete this checklist before seeing your doctor or nurse. Your responses will help us provide the best care.

Social History	
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	#Children _____ #Miscarriages_____ #Abortions _____
Tobacco Use: ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Never ☐ Quit Date: _____ ☐ Packs/day _____ ☐ # of years _____	
Caffeine: ☐ Yes ☐ No ☐ Coffee: Cups/day_____ ☐ Energy drinks/day _____	**Alcohol:** ☐ Yes ☐ No ☐ Drinks/day _____ Is alcohol a concern for you/others? ☐ Yes ☐ No
Drug Use: Have you ever used non-legalized drugs? ☐ Yes ☐ No Cannabis ☐ Yes ☐ No Vaping ☐ Yes ☐ No Have you ever used needles to inject drugs? ☐ Yes ☐ No	**Sexual Activity:** Sexually active: ☐ Yes ☐ No ☐ Not currently Current sex partner ☐ Male ☐ Female Birth Control method: _____ ☐ Not needed Have you ever had a sexually transmitted infection (STI)? ☐ Yes ☐ No Are you interested in being screened for a sexually transmitted infection (STI)? ☐ Yes ☐ No

Surgeries		**Type of Surgery**	**Date Performed**
Abdominal	☐ Yes ☐ No		
Appendix	☐ Yes ☐ No		
Breast	☐ Yes ☐ No		
Gall Bladder	☐ Yes ☐ No		
Heart	☐ Yes ☐ No		
Orthopedic	☐ Yes ☐ No		
Prostate	☐ Yes ☐ No		
GYN	☐ Yes ☐ No		
Urologic	☐ Yes ☐ No		
Knee Replacement	☐ Yes ☐ No		
Hip Replacement	☐ Yes ☐ No		
Heart Valve Replacement	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

Past Testing		**Date Performed**
Bone Density	☐ Yes ☐ No	
Colonoscopy	☐ Yes ☐ No	
EKG	☐ Yes ☐ No	
Mammogram	☐ Yes ☐ No	
PAP Smear (Females)	☐ Yes ☐ No	
Prostate Screening (Males)	☐ Yes ☐ No	
Pulmonary Testing	☐ Yes ☐ No	
Stress Testing	☐ Yes ☐ No	

Other Concerns:	
Weight: Is your weight a concern? ☐ Yes ☐ No	
Diet: How do you rate your diet?	
Exercise: Do you exercise regularly? ☐ Yes ☐ No What kind of exercise? _____ How long (minutes) _____ How often? #____/week	
Are you currently taking/planning to take bisphosphonates (Osteoporosis /Low Bone mineral density)?	☐ Yes ☐ No

Mental Well-being	
Have you felt down, depressed or hopeless during the past month?	☐ Yes ☐ No
Often having little pleasure in doing things during the past month?	☐ Yes ☐ No
Rate your overall stress level	☐ Low ☐ Medium ☐ High

Health Questionnaire

Medication	Dose	Times/Day

Medication	Dose	Times/Day

Allergies or reactions: To medication, food, environment, or other agent.

☐ No known allergies or reactions to any medications

Medication, Food, Other	Reaction or Side Effect	Date it Occurred

Family History: ☐ Adopted ☐ Family History Unknown

Family History *Check all that apply*	Mental health Disorder	Alcohol	CANCER					Diabetes	High Blood Pressure	High Cholesterol	Cause of Death	Other
			Breast	Colon	Prostate	Uteri an	Lung					
Father												
Mother												
Maternal Grandfather												
Maternal Grandmother												
Paternal Grandfather												
Paternal Grandmother												
Brothers												
Sisters												

Informing Materials

The following information is for all patients of Hurtt Family Health Clinic

1. Authorization for Treatment
2. HIPAA Notice of Privacy
3. Patient Bill of Rights
4. Patient's Responsibilities
5. Advance Directive
6. Additional Consents

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:

1. To treat disease, injury and disability by examination, testing and use of procedures as needed, in the aid of diagnosis or treatment.
2. To obtain information needed in diagnosing and examining patients.
3. To prevent or minimize residual physical and mental disability.
4. To aid patients in achieving their maximum potential within their capabilities.
5. 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.

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:

1. Power of Attorney for Health Care (to appoint an agent)
2. 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.

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.

CAIR Notice

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's your right to limit who is able to access your records in the California Immunization Registry (CAIR).

Dental Facts

See attached dental fact sheet.