

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
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Address	Apt./Unit	City	State	Zip Code
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SSN	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address
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Please check primary phone	<input type="checkbox"/> Home Phone ()	<input type="checkbox"/> Cell Phone ()	<input type="checkbox"/> Work Phone ()
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Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Do you need an interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Race <small>(Please check all that apply):</small>	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Black/African American	<input type="checkbox"/> White
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Chose Not to Disclose Race
	<input type="checkbox"/> Korean	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Samoan			

Ethnicity: <input type="checkbox"/> Mexican <input type="checkbox"/> Chicano <input type="checkbox"/> Cuban <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline to Specify	Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Sexual Orientation:					
<input type="checkbox"/> Straight	<input type="checkbox"/> Lesbian or Gay	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Don't know	<input type="checkbox"/> Chose Not to Disclose	<input type="checkbox"/> Other: _____

Gender Identity: <small>(How do you identify yourself?)</small>	<input type="checkbox"/> Male <input type="checkbox"/> Transgender Man/Transgender Male/Transmasculine	<input type="checkbox"/> Choose Not to Disclose
	<input type="checkbox"/> Female <input type="checkbox"/> Transgender Woman/Transgender Female/Transfeminine	<input type="checkbox"/> Other: _____

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Health Insurance: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Other: _____	Do you have an Advanced Directive: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you a Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you an Agricultural Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, please select a class of work</i> <input type="checkbox"/> Migratory <input type="checkbox"/> Seasonal
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Have you ever been homeless in the current calendar year? <small>(January-December)</small> <input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please select a living arrangement for the current year (Check one):

<input type="checkbox"/> Permanent Supportive Housing <small>(housing assistance provided e.g., long-term leasing or rental assistance)</small>	<input type="checkbox"/> Transitional <small>(housing transition from a shelter and are provided extended, but temporary, housing stays)</small>	<input type="checkbox"/> Doubling Up <small>(living with other people for a temporary period and move often, unstable)</small>	<input type="checkbox"/> Other <small>(hotel, motel, day-to-day single room occupancy)</small>
<input type="checkbox"/> Homeless Shelter <small>(safe havens, temporary overnight housing, armories)</small>	<input type="checkbox"/> Street <small>(living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter)</small>		

Pharmacy

Preferred Pharmacy Name:	Pharmacy Address:
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Spouse or Parent/Guardian Information: (If applicable)

Last Name	First Name	Date of Birth
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Please check primary phone	<input type="checkbox"/> Home Phone ()	<input type="checkbox"/> Cell Phone ()	<input type="checkbox"/> Work Phone ()
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Emergency Contact:

Last Name	First Name	Relation to the Patient	Phone Number ()
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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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Health Center Program Information for Uninsured/Underinsured Patients

The Hurtt Family Health Clinic cares about your family's health! As your medical home, we work hard to provide you with high quality, comprehensive low to no cost health care services for you and your family based on your ability to pay. We also **partner** with our families to assess and enroll our patients into many health programs offered by local, state, and federal government to give you with the best options for covering the cost of your care. *Please note that each of these programs requires certain documents and information, and we appreciate your cooperation in providing us with this information.*

The **Sliding Fee Scale Program** is based on family size and income, which is determined by the annual Federal Poverty Guidelines. Patients will be given a percentage discount based on the sliding fee scale.

To apply for any available health program, the following documentation is required:

Verification of Income: (Only one (1) of the following)

- Current paycheck stub
- Tax Return
- Letter from employer, family, friend who are assisting with expenses

Identification: (Only one (1) of the following)

- Current Driver's License
- Government Issued Photo Identification Card
- School Photo Identification Card
- Check Cashing Photo Identification Card

Proof of Address: (Only one (1) of the following)

- Utility Bill with your name and address
- Current Driver's License
- Rent or lease receipt or agreement
- Any non-junk mail addressed to adult patient or child (under age 18) parent or guardian in the last 60 days

As a patient of HFHC, you will be responsible for:

- Presenting all required information for any health program at the time of service
- Providing updated information on an annual basis
- Providing payment at the time of service

HFHC staff is available to help you with any questions you may have about this program and reasonable payment options that work for you. If you have questions, please call (714) 247-0300 to speak with a Call Center Staff. Please help us continue to provide health care services to all in need by paying what you can and remember ***no one will be turned away due to inability to pay. We know that you have a choice when it comes to your family's medical care and we thank you for choosing Hurtt Family Health Clinic for your health care needs.***

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:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Paystub • Federal/State Income Tax Form • Wages and Tax Statement (e.g. W-2) • Foreign Income • Self-employment ledger documentations | <ul style="list-style-type: none"> • 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: _____

Notice of Privacy Practices Consent Form

Account Number: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law. You confirm that you have reviewed our notice before signing this consent by your signature.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

If YES, 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 ()

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)