HURTT familyhealth CLINIC

Patient Registration 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** ☐ 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/Alaska 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 ☐ Transgender Man/Transgender Male/Transmasculine ☐ Transgender Woman/Transgender Female/Transfeminine ☐ Choose Not to Disclose ☐ Other:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Health Insurance: ☐ Medi-Cal ☐ Medicare ☐ 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

Have you ever been homeless in the current calendar year? *(January-December)* ☐ Yes ☐ No

If yes, please select a living arrangement for the current year (Check one):

☐ **Permanent Supportive Housing** (housing assistance provided e.g., long-term leasing or rental assistance)

☐ **Transitional** (housing transition from a shelter and are provided extended, but temporary, housing stays)

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

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

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

☐ **Street** (living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter)

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:

Account Number: _____

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.***

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

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)

Account Number: _____

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)

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Account #:_____

HURTT familyhealth CLINIC

Annual Universal Screening

All information on this form is CONFIDENTIAL.

Money and Resources

What is your housing situation today?
☐ I have housing
☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐ I choose not to answer this question

Are you worried about losing your housing?
☐ Yes ☐ No ☐ I choose not to answer this question
Do you have any concerns today about your housing situation? (Please write):

What is the highest level of school that you have finished?
☐ Less than high school degree ☐ High school diploma or GED ☐ More than high school ☐ I choose not to answer this question

What is your current work situation?
☐ Unemployed and seeking work ☐ Part time or temporary work ☐ Full time work
☐ Otherwise unemployed but not seeking work (ex. Student, retired, disabled, unpaid primary care giver)
☐ I choose not to answer this question

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply:
☐ Food ☐ Utilities ☐Clothing ☐ Childcare ☐ Medicine or any health care ☐ Phone ☐ I choose not to answer this question
☐ Other (please write):

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply:
☐ Yes, it has kept me from medical appointments
☐ Yes, it has kept me from non-medical meetings, appointments, work, or from things I need
☐ No
☐ I choose not to answer
Do you have any concerns today about transportation? (Please write):

Social and Emotional Health

How often do you see or talk to people that you care about and feel close to? (for example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 to 5 times a week ☐ More than 5 times a week
☐ I choose not to answer this question

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep, or can't sleep at night because their mind is troubled
☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very Much ☐ I choose not to answer this question

Additional Questions

In the past year have you spent more than 2 nights in a row in a jail, detention center, or juvenile correctional facility?
☐ Yes ☐ No ☐ I choose not to answer this question

What country are you from?
☐ United States ☐ Other than the United States _____ ☐ I choose not to answer this question

Are you a refugee or someone seeking asylum? ☐ Yes ☐ No ☐I choose not to answer this question

Do you feel physically and emotionally safe where you currently live?
☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer this question
Do you have any other concerns today? (Please write):

In the past year, have you been afraid of your partner, ex-partner, or a member in your family or friend group?
☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer this question
Do you have any other concerns today? (Please write):

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MEDIA CONSENT FORM

This form provides consent for the use of photographs, video recordings, and/or other related media involving the individual named below. This consent complies with all relevant healthcare privacy laws, including HIPAA (Health Insurance Portability and Accountability Act).

Patient Information:
Medical Record Number: _____ Name: _____

Authorization for Use/Disclosure:
I, the undersigned, authorize Hurtt Family Health Clinic, its representatives, and affiliates, including healthcare providers, communications staff, and approved third parties, to obtain photographs, video or film in which I appear, herein referenced as media.

Purpose of Use/Disclosure:
The media will be used for the following purposes:

- Social media (e.g. Facebook, Instagram, LinkedIn)
- Newsletters
- Hurtt Family Health Clinic website
- Other platforms that Hurtt Family Health Clinic manages for public use

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Terms and Conditions:

- I understand that the media may be used or disclosed for the purposes stated above and may be shared with third parties (e.g., media outlets, public platforms).
- I understand that I may refuse to sign this form and that my refusal will not affect my medical treatment, payment, or eligibility for benefits.
- I may revoke this consent at any time by providing a written notice to Hurtt Family Health Clinic. However, such revocation will not apply to materials already in use or prepared prior to the revocation.
- I acknowledge that I am not entitled to compensation for the use of the media or related materials.

Expiration of Authorization:
This consent will remain in effect until:

- Date: _____ Leave blank if you choose not to expire this consent.

Acknowledgment and Release:

☐ I hereby release and hold harmless Hurtt Family Health Clinic, its representatives, and third parties authorized under this consent from any and all liability arising from the use or disclosure of the authorized media.

Patient's Signature: _____ Date: _____

If the patient is a minor or unable to consent:

Name of Representative: _____ Relationship to Patient: _____

Representative's Signature: _____ Date: _____

OR

☐ **Refuse to give consent** Sign: _____ Date: _____

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Informing Materials

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

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

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.

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.

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient of Hurtt Family Health Clinic, you have the right to:

1. Access to Care: Individuals shall be accorded impartial access to treatment or accommodations as to their requests and needs for treatment or services that are within the health clinic's capacity, availability, its stated mission and applicable law and regulation.

2. Respect and Dignity: All individuals, whether adult, adolescent or newborn, have the right to considerate, respectful care at all times and under all circumstances, with recognition of their personal dignity and the psychosocial, spiritual and cultural variables that influence their perceptions of illness.

3. Privacy and Confidentiality: The patient (or his/her parent or legal designated representative) has the right, within the law, to personal and informational privacy, as manifested by the right to:
   a. Receive appropriate treatment in the least restrictive setting available.
   b. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand.
   c. Refuse to talk with or see anyone not officially connected with the health clinic, including visitors, or persons officially connected with the health clinic but who are not directly involved in his/her care.
   d. Wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatment.
   e. Be interviewed and examined in surroundings designed to assure reasonable audiovisual privacy. This includes the right to have a person of one's own sex present during certain parts of a physical examination, treatment or procedure performed by a health professional of the opposite sex.
   f. Participate in the development and implementation of your plan of care
   g. Expect that any discussion or consultation involving the patient's case, whether adult, adolescent or newborn, will be conducted discreetly, and that individuals not directly involved in his/her care will not be present without his/her permission.
   h. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services.
   i. Have the right to review his/her medical records and have the information explained, except when restricted by law.
   j. Have the medical records read only by individuals directly involved in the treatment or the monitoring of its quality, and by other individuals only on the patient's (or his/her parents or legal designated representative) written authorization. When the records are released to insurers, that confidentiality is emphasized.
   k. Treatment of all communications and records. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

l. Expect all communications and other records pertaining to his/her care, including the source of payment for treatment, to be treated as confidential.
m. Be placed in protective privacy when considered necessary for personal safety.

4. Personal Safety: The patient, whether adult, adolescent or newborn, has the right to expect reasonable safety insofar as the health clinic practices and environment are concerned. This includes the right to a humane treatment environment that provides reasonable protection from harm and appropriate privacy for personal reasons.

5. Identity: The patient (or his/her parent or legal designated representative) has the right to know the identity and professional status of individuals providing service to him/her and to know which physician or other practitioner is primarily responsible for his/her care.

6. Information: The patient (or his/her parent or legal designated representative) has the right to obtain from the practitioner responsible for coordination of his/her care complete and current information concerning his/her diagnosis (to the degree known) treatment and any known prognosis.

7. Communication: When the patient (or his/her parent or legal designated representative) does not speak or understand the predominant language of the community, he/she should have access to an interpreter.

8. Consent: The patient (or his/her parent or legal designated representative) has the right to the information necessary to enable hi/her, in collaboration with the health care practitioner, to make treatment decisions involving his/her health care that reflect his/her wishes.

9. Consultation:
   a. The patient (or his/her parent or legal designated representative) has the right to accept medical care or to refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. When refusal of treatment by the patient (or his/her parent or legal designated representative) prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.
   b. Examine and receive an explanation of the clinic's bill regardless of the source of payment.

10. Transfer and Continuity of Care: A patient has the right to expect that the health clinic will give necessary health services to the best of its ability. Treatment, referral or transfer may be recommended. If transfer is recommended or requested, the patient will be informed of risks benefits and alternatives.

11. Delineation of Patient's Rights: The rights of the patient may be delineated on behalf of the patient, to the extent permitted by law, to the patient's guardian, next of kin or legally authorized responsible person.

12. Rules and Regulations: The patient (or his/her parent or legal designated representative) should be informed of the health clinic rules and regulations applicable to his/her conduct as a patient.

13. Rights: Receive care without regard to sex, economic status, educational background, race, color, age, religion, ancestry, national origin, sexual orientation, gender identity or expression, marital status, registered domestic partner status, disability, medical condition, genetic information,

citizenship, primary language, immigration status (except as required by federal law) or ability to pay (defined by sliding scale).

PATIENT RESPONSIBILITIES

Healthcare is a shared responsibility. Engaging in discussion, asking questions, seeking information, and exploring alternatives improves communication and understanding of one's health and treatment. As a patient of Hurtt Family Health Clinic, you have the following responsibilities:

1. Patients, as well as their family members, representatives and visitors, are expected to recognize and respect the rights of our other patients, visitors, and staff. Threats, violence, disrespectful communication or harassment of other patients or of any medical center staff member, for any reason, including because of an individual's age, ancestry, color, culture, disability (physical or intellectual), ethnicity, gender, gender identity or expression, genetic information, language, military/veteran status, national origin, race, religion, sexual orientation, or other aspect of difference will not be tolerated. This prohibition applies to the patient as well as their family members, representatives, and visitors.
2. To respect the rights and property of other patients and Hurtt Family Health Clinic personnel and facility. Just as you want privacy, a quiet atmosphere and courteous treatment, so do other patients. You have the responsibility to follow the organization's rules and regulations, limit your visitors, and use the telephone, courteously so that you do not disturb others.

3. In addition, requests for changes of provider or other medical staff based on that individual's race, ethnicity, religion, sexual orientation or gender identity will not be honored. Requests for provider or medical staff changes based on gender will be considered on a case by case basis and only based on extenuating circumstances.

4. Refrain from using a smart device to record your experience in audio, video or photography format in Hurtt Family Health Clinic without the consent of everyone involved including Medical Center physicians, nurses, and other staff. Please note that unauthorized recording violates California State Law and is prohibited. To discuss any concerns with establishing trust, please contact the Clinic Manager that is caring for you for support.

5. For the safety of all patients, visitors, faculty, and staff, do not bring any weapons alcohol products, or illegal substances onto health system property including but not limited to guns, knives, pepper spray (or similar), or Tasers/stun guns, etc. This can lead to dismissal from Hurtt Family Health Clinic.

6. The patient (or his/her parent or legal designated representative) has the responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.

7. The patient (or his/her parent or legal designated representative) has the responsibility to report unexpected changes in his/her condition to the responsible practitioner. A patient is responsible for making it known whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.
8. A patient (or his/her parent or legal designated representative) is responsible for following the treatment plan recommended by the practitioner primarily responsible for his/her care.

9. The patient (or his/her parent or legal designated representative) is responsible for his/her actions if he/she refuses treatment or does not follow the practitioner's instructions. If the patient cannot

follow through with the treatment, he/she is responsible for informing the practitioner primarily responsible for his/her care.

10. The most effective plan is the one to which all participants agree and that is carried out exactly. It is your responsibility to tell your health care provider whether or not you can and want to follow the treatment plan recommended for you.

11. A patient's health depends not just on his/her care but, in the long term, on the decisions he/she makes in his/her daily life. He/she is responsible for recognizing the effect of lifestyle on his/her personal life.

12. To accept the consequences of your own decisions and actions, if you choose to refuse treatment or not to comply with the care, treatment, and service plan offered by your healthcare provider.

13. To keep appointments with your healthcare provider. If you need to cancel an appointment, you should do so at least 24 hours before your appointment time.

14. To assure that you're financial obligations for your healthcare are fulfilled by paying bills promptly. Late payments increase overall charges. You are responsible for working with Hurtt Family Health Clinic staff, to make payment arrangements and for providing the information necessary to determine how your bill will be paid.

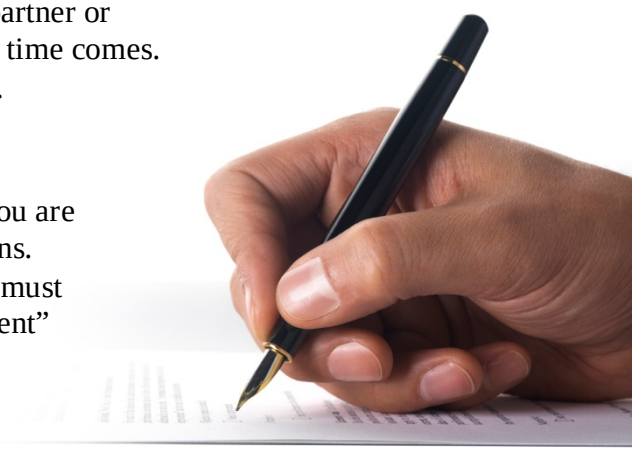
15. Any abusive or disrespectful behavior may result in dismissal from Hurtt Family Health Clinic's care.

If you have any questions regarding these Patient Responsibilities, please contact:
Hurtt Family Health Clinic at 714-247-0300

Advance Directives: What You Need to Know

What Is An Advance Directive?

- An Advance Directive is a document that states in writing your wishes about what type of care you would want or do not want, in case you get hurt, sick or become unable to make medical decisions for yourself.
- On the form, you may choose an adult relative, spouse, partner or friend as your "agent" to make these decisions when the time comes.
- You must sign your name and write the date on the form.



Where Do I Begin?

- You can write or fill out your own advance directive if you are 18 years or older, and are able to make your own decisions.
- You do not need a lawyer to fill out the document, but it must be signed by a notary public or by 2 witnesses. Your "agent" cannot be one of the witnesses.

Choose A Person You Trust.

- After you choose this person, talk to them in detail about what you want. Make sure this person knows your wishes and are willing to make them for you.
- Talk with your doctor and "agent" about what you want and give them both a copy.
- Your doctor may ask you to sign a form that states you have talked to them about this document.

Can I Change My Mind?

- You may change or cancel your advance directive at any time, as long as you are aware of how the choices impact your health care. Being aware means you can still think and voice your wishes in a clear manner. You can also change your "agent."
- Make sure that your doctor and your "agent" know about any changes.

Why Sign One Now When I'm Healthy?

- The best time to sign an advance directive is when you are healthy, and are able to think and speak for yourself. Having a plan in place will ensure that your wishes are followed.

Where Can I Get The Advance Directive Document?

- Most hospital emergency rooms and the Orange County Office on Aging have these forms. Call **1-800-510-2020** for more information. You do not need to use a form. You can also write your wishes down on paper and have this document signed instead.
- Contact Caring Connections at **www.caringinfo.org**.

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