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**

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

Address	**Apt./Unit**	**City**	**State**	**Zip Code**

Sex at Birth ☐ Male ☐ Female	**Email Address**

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

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

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	**Health Insurance:** ☐ Medi-Cal ☐ Medicare ☐ None ☐ Other: _____	**Do you have an Advanced Directive:** ☐ Yes ☐ No

How many people are supported by your household income? _____

What is your household's total income before taxes? $_____ ☐ Weekly ☐ Monthly ☐ Annually

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

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

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 Family Health Clinic

Sliding Fee Program Application

❒ Initial ❒ Annual Review

❒Update/Reason for Update: ❒ Income ❒ Marital Status ❒ Address ❒ Family Size ❒ Work Status ❒ Insurance Coverage

This area for office use only.

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 disclose your health information for purposes of treatment, payment, and healthcare operations? Examples include:

- Appointments
- Treatment
- Payment: Billing/Insurance
- Healthcare Operations: Activities to improve the quality of care we provide.

☐ Yes ☐ No

If YES, please list any persons you would like to have access to your appointments, treatment, billing, or other healthcare operations 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)

HURTT familyhealth CLINIC

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)

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: _____