VALLEY VIEW HEALTH CENTER

PATIENT INFORMATION

LAST NAME (LEGAL NAME):	**FIRST NAME (LEGAL NAME):**	**TODAY'S DATE:** / **PREFERRED NAME:**
SOCIAL SECURITY #:	**DATE OF BIRTH:**	
SEX ASSIGNED AT BIRTH: □ Male □ Female	**CURRENT GENDER:**	□ Male □ Female

GENDER IDENTITY*: □ Male □ Female □ Genderqueer □ Transgender Man/Female-to-Male □ Choose not to disclose □ Transgender Woman/Male-to-Female □ Additional Gender (please specify):_____

SEXUAL ORIENTATION*: □ Straight/Heterosexual □ Bisexual □ Gay □ Lesbian □ Unsure □ Choose not to disclose □ Additional Orientation (please specify): _____

**We recognize these lists are not inclusive, based on limitations of our Electronic Health Record. Thank you for understanding.*

MAILING ADDRESS:	**CITY**	**STATE**	**ZIP**
PHYSICAL ADDRESS:	**CITY**	**STATE**	**ZIP**

MARITAL STATUS:	**PREFERRED LANGUAGE:**

HOME #:	**CELL #:**	**EMAIL:**
NOTIFICATIONS (Appointment Reminders, Patient Portal Communications, etc.)		□ Opt In □ Opt Out

INSURANCE INFORMATION

MEDICAL ***If you have multiple insurances, please list those on the back of this form.***

INSURANCE CO:	**SUBSCRIBER/POLICY #:**	**EFFECTIVE DATE:**
GROUP #:	**BILLING/CLAIMS ADDRESS:**	
INSURED/SUBSCRIBER (If someone other than the patient):	**LAST NAME:**	**FIRST NAME:**
RELATION TO PATIENT:	**DATE OF BIRTH:**	

DENTAL ***If you have multiple insurances, please list those on the back of this form.***

INSURANCE CO:	**SUBSCRIBER/POLICY #:**	**EFFECTIVE DATE:**
GROUP #:	**BILLING/CLAIMS ADDRESS:**	
INSURED/SUBSCRIBER (If someone other than the patient):	**LAST NAME:**	**FIRST NAME:**
RELATION TO PATIENT:	**DATE OF BIRTH:**	

PERSON RESPONSIBLE FOR ACCOUNT *Complete if someone other than the patient*

LAST NAME:	**FIRST NAME:**	**DATE OF BIRTH:**
RELATION TO PATIENT:	**PHONE #:**	

DATA SURVEY

Answering these questions may help Valley View Health Center obtain funding for services. Please note that this information is de-identified and your personal information will NOT be shared.

HOUSING STATUS:
□ Permanent Home/Renting
□ Doubling Up
□ Shelter
□ Street
□ Transitional
□ Unknown / Unreported

AGRICULTURAL WORKER STATUS:
□ Not a farmworker
□ Migrant
□ Seasonal

RACE* (Check all that apply):
□ American Indian/Alaskan Native
□ Asian Indian
□ Black/African American
□ Chinese
□ Filipino
□ Guamanian/Chamorro
□ Japanese
□ Korean
□ Native Hawaiian
□ Other Asian
□ Other Pacific Islander
□ Samoan
□ Vietnamese
□ White
□ Decline

ETHNICITY*:
□ Chicana/o
□ Cuban
□ Hispanic (Latino)
□ Mexican
□ Mexican American
□ Non-Hispanic (Latino)
□ Puerto Rican
□ Spanish Origin
□ Decline
□ Other: _____

VETERAN STATUS:
□ Yes □ No

FAMILY SIZE (Click/Circle one): 1 2 3 4 5 6 7 8+

ESTIMATED ANNUAL HOUSEHOLD INCOME: $

PREFERRED PHARMACY (Name & Location): □ Valley View Health Center Pharmacy □ Other: _____

HOW DID YOU HEAR ABOUT US? □ Advertisement □ Community Event □ Friend/Family □ Hospital □ Social Media □ Other:_____

VALLEY VIEW HEALTH CENTER

Patient Name: _____ Date of Birth: _____

Acknowledgement & Authorization

I have read and understand the HIPAA/Privacy Policy for Valley View Health Center. *Scan the QR code to read the document:*
I hereby assign my insurance benefits to be paid directly to Valley View Health Center. I understand that I am financially responsible to Valley View Health Center for services not paid by insurance or other third-party payers.
I authorize Valley View Health Center to release my healthcare information required to process my claim.
I understand Valley View Health Center's **appointment policy**: Two or more missed appointments or same day cancellations may result in being placed on standby status, meaning I will not be able to pre-schedule appointments for six months and will need to call the clinic upon opening to check same-day appointment availability.
I authorize Valley View Health Center to obtain my photograph and/or scan my government issued photo ID as proof of identity. If I decline a photograph or scanning of my ID, I will show proof of identity at every visit.
I understand children younger than 18 years of age must be accompanied by a parent/guardian who stays at the clinic for the entire appointment. Minors are not allowed to be left in our waiting room without adult supervision.
I have been offered a copy of Valley View Health Center's Patient Rights and Responsibilities form. *Scan the QR code to read the document:* Adults Pediatrics

Health Insurance Portability & Accountability Act (HIPAA)/Privacy Policy & Emergency Contact

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below.

Please list the names of persons authorized by you to receive your health information, verbally, pick up medication, prescriptions, copies of personal paperwork or contact in the event of an emergency.

Name	Name
Relationship	Relationship
Phone Number	Phone Number

_____ _____

Signature Print Name

☐**Patient** / ☐**Parent** / ☐**Guardian**

Check relationship

_____

Date

VALLEY VIEW HEALTH CENTER

CONSENT TO CARE & TREATMENT
FINANCIAL AUTHORIZATION
ACKNOWLEDGMENTS

Patient Name: _____ **Date of Birth**: _____

I (individually or on behalf of the patient named above) consent to outpatient care and treatment at Valley View Health Center, a federally qualified health center providing a range of health care services, including primary medical care, dental care, behavioral health care and pharmacy services. Such care may include routine diagnostic procedures, examinations and treatment including (but not limited to) routine laboratory work and administration of medications as prescribed.

I understand that I may also be asked to sign separate department-specific consents and authorizations, particularly for invasive or complex medical or dental procedures, behavioral health treatment or other matters in which the risks and benefits of care or treatment are not typically described as "routine." Consents for a "series" of outpatient procedures or treatment will be updated at least once annually.

I understand that if I am consenting for the treatment of a minor, I may be asked to sign additional documents related to the care and treatment of a minor and my role in authorizing such care. If I am pregnant, or become pregnant, my consent for treatment includes consent for treatment of my unborn child.

I understand that VVHC partners with educational institutions and student(s) may participate in my care under the supervision of VVHC provider(s).

I authorize Valley View Health Center to bill for all services provided, and I have separately provided Valley View Health Center with my health insurance coverage and family financial information to be used in conjunction with such billings to determine if care or services are subject to Valley View Health Center's sliding fee scale discounts. I will update my family income and health coverage information whenever such information changes. I understand I am responsible for all co-pays and deductibles required by my health plan. I understand that if care or treatment is not generally covered by my health plan or program I may be billed directly for such services. In that instance, I am entitled to request a Good Faith Estimate of the charges for non-covered services in advance of receiving such care or treatment.

I acknowledge that I have received, or been offered, each of the following documents, and I understand that I may request a copy of any of these Valley View Health Center documents at any time:

- New Patient Packet (Adult/Peds)
- Statement of Privacy Practices (HIPAA)
- Patient Rights & Responsibilities
- Medication Policy
- Right to Good Faith Estimate of Charges
- Sliding Fee Scale Schedule & Process for Qualification for Reduced Fees
- Discount Drug Pricing
- Health Care Advance Directives / Mental Health Advance Directives

_____
☐Patient / ☐Parent / ☐Guardian (Signature)
Check relationship

_____
☐Parent / ☐Guardian / ☐Guarantor Name (Print)
Check relationship

Date:_____