VALLEY VIEW HEALTH CENTER

PATIENT INFORMATION	TODAY'S DATE:
LEGAL NAME (LAST, FIRST):	PREFERRED NAME:
SOCIAL SECURITY #:	DATE OF BIRTH:
SEX ASSIGNED AT BIRTH: ☐ Male ☐ Female	CURRENT GENDER: ☐ Male ☐ Female

MAILING ADDRESS:	CITY	STATE	ZIP
PHYSICAL ADDRESS: *(*if different from above)*	CITY	STATE	ZIP

HOME #:	CELL #:
EMAIL:	PREFERRED LANGUAGE:

APPOINTMENT REMINDERS ☐ Opt In ☐ Opt Out **(Please note: If you opt out, you are still responsible for your child to attend their appointment and/or notify the clinic if you need to cancel or reschedule their appointment).**

DEMOGRAPHIC INFORMATION

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

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

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

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

FAMILY SIZE (Circle one): 1 2 3 4 5 6 7 8+	ESTIMATED ANNUAL HOUSEHOLD INCOME: $

RESPONSIBLE PARTY & PARENT/GUARDIAN INFORMATION

PRIMARY RESPONSIBLE PARTY **Will receive billing statements and primary communication* (LAST, FIRST):	DATE OF BIRTH:
PRIMARY PHONE #:	RELATION TO PATIENT:
SECONDARY PARENT/GUARDIAN *(*if applicable)* (LAST, FIRST):	DATE OF BIRTH:
PRIMARY PHONE #:	RELATION TO PATIENT:

INSURANCE INFORMATION ☐ NO INSURANCE / SELF PAY

PRIMARY INSURANCE COMPANY NAME:	SECONDARY INSURANCE COMPANY NAME:
SUBSCRIBER/POLICY #:	SUBSCRIBER/POLICY #:
POLICY HOLDER NAME (LAST, FIRST):	POLICY HOLDER NAME (LAST, FIRST):
DATE OF BIRTH:	DATE OF BIRTH:
RELATION TO PATIENT:	RELATION TO PATIENT:

PREFERRED PHARMACY (Name & Location): ☐ Valley View Health Center Pharmacy ☐ 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 (VVHC).
I hereby assign my insurance benefits to be paid directly to VVHC. I understand that I am financially responsible to VVHC for services not paid by insurance or other third-party payers. I authorize VVHC to appeal/dispute, on my behalf, any service that is denied or inappropriately paid. This authorization applies to all payers/insurances deemed responsible for coverage of services and includes all appeals, disputes and/or escalations up to and including the Washington State Office of the Insurance Commissioner.
I authorize VVHC to release my healthcare information required to process my claim. This authorization is effective for all services performed by VVHC and includes release of my healthcare information which may include benefit, claim, diagnosis and treatment records including sensitive healthcare diagnosis and treatment.
I understand payments made for services that result in a credit will be applied to any outstanding balances owed.
I authorize VVHC 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 understand VVHC may utilize HIPAA compliant artificial intelligence tools during the course of my visit.

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 individuals 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.**

Authorized Individuals/Emergency Contacts:

Name: ____________________ Phone: ________________ Relationship: ____________

Name: ____________________ Phone: ________________ Relationship: ____________

Name: ____________________ Phone: ________________ Relationship: ____________

X ______________________________ ______________________________

Signature **Print Name**

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

Check relationship

____

Date

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.

**If I have Medicare coverage, I understand Medicare covers Advanced Primary Care Management (APCM) services provided monthly by physician practices. I understand that my primary care physician is assuming responsibility for all my primary care services. Please visit our website www.vvhc.org/insurances for more information.

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. I understand I am responsible for all co-pays, co-insurance, 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 was offered a resource card with links to the following documents and I understand that I may request a hard copy of any of these documents at any time:

- 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

X ____________________________________
Signature

☐ **Patient/** ☐ **Parent /** ☐ **Guardian**
Check relationship

____
Print Name

____
Date

VALLEY VIEW
HEALTH CENTER

Parent/Guardian Authorization For Another Adult To Make Health Care Decisions for a Minor

Autorización de los padres/tutores para que otro adulto tome decisiones sobre la atención médica de un menor de edad

Patient Name / *Nombre del Paciente*: ____

Date of Birth / *Fecha de Nacimiento*: _______________________ Date / *Fecha*: ____________________________

I hereby authorize the following adult(s) to make health care decisions for the minor patient named above and to provide all necessary written and/or verbal consent for treatment in the same manner and with the same effect as if I had provided such authorization and consent.

Por la presente doy poder al(los) siguiente(s) adulto(s) para tomar decisiones sobre la atención médica del paciente menor de edad mencionado anteriormente y a autorizar todo el consentimiento escrito y/o verbal necesario para el tratamiento de la misma manera y con el mismo efecto que si yo hubiera estado de acuerdo con dicha autorización y consentimiento.

Name / *Nombre*	Relationship / *Relación*

I authorize these adults to consent to any and all necessary medical and dental health care (including immunizations) in my absence. I accept full responsibility for any provider, clinic, and/or laboratory fees.

Autorizo a estos adultos a que den su consentimiento para toda la atención médica y dental necesaria (incluidas las vacunas) en mi ausencia. Acepto toda la responsabilidad por las facturas de cualquier proveedor, clínica y/o laboratorio.

***Please Note: This does not allow authorized adults to request any health history or chart information unless indicated on our additional disclosure form.**

**Nota: Esto no permite a los adultos autorizados solicitar historial médico o información de la historia clínica a menos que se indique en nuestro formulario de divulgación adicional.*

_______________________________________ _______________________________________

Parent or Guardian Signature
Firma del Padre o Tutor

Parent or Guardian Name
Nombre del Padre o Tutor

Expiration or Termination. All aspects of this consent will be in effect until terminated in writing by the parent or guardian or on the date the minor becomes an adult under state law.

Expiración o terminación. Todos los aspectos de este consentimiento estarán en vigor hasta que los padres o tutores lo den por terminado, por escrito, o en la fecha en que el menor de edad se convierta en adulto según la ley estatal.

OFFICE USE ONLY

Verbal Consent Obtained: □ Yes □ No Consent given by: _______________________ VVHC Staff Initials: ________

VALLEY VIEW
HEALTH CENTER

Appointment Cancellation Policy & Behavioral Agreement

Patient Name: ________________________________ Date of Birth:________________

Thank you for choosing Valley View Health Center for your healthcare needs. To ensure the best possible experience for all of our patients, we ask that you review and agree to the following policies regarding appointment cancellations and appropriate behavior in our office.

CANCELLATION POLICY

Timely Notice: If you need to cancel or reschedule an appointment, ***we require at least 24 hours' notice***. This allows us to accommodate other patients in need of care.

Late Cancellations & No Shows: Appointments canceled with less than 24 hours' notice or missed without prior notification may be subject to a **$50.00 cancellation fee** if your insurance allows (this fee is not billable to your insurance).

Same Day Cancellations & No Shows: Patients who accrue two (2) same day cancellations or no shows, regardless of department will be placed on standby status. Patients on standby must call for a same day appointment or arrive when the clinic opens to wait for a same day appointment. Standby status is valid for 6 months from the date of the second late cancel or no show.

Appointment Reminders: You will receive automated and/or verbal reminders ahead of your appointment. However, if reminders are not sent or you choose to opt out, it remains your responsibility to attend your scheduled appointment.

BEHAVIORAL GUIDELINES

To maintain a respectful and welcoming environment for all, we ask that all patients adhere to the following:

Respectful Communication: Patients and visitors are expected to communicate with staff and other patients in a courteous and respectful manner.

Zero Tolerance for Harassment: We do not tolerate abusive language, threats, or any form of harassment towards staff or other patients.

Punctuality: Please arrive on time for your appointment. If you are more than 10 minutes late, your appointment may need to be rescheduled.

Health & Safety: To protect the health of others, please inform us if you are experiencing symptoms of a contagious illness before coming in.

Compliance with Office Policies: Patients must follow all posted office policies and directions given by staff.

Acknowledgment & Agreement
By signing below, you acknowledge that you have read, understand, and agree to abide by the cancellation policy and behavioral guidelines outlined above.

________________________________ ________________________________

Signature **Date**

☐ **Patient /** ☐ **Parent /** ☐ **Guardian** (*Check Relationship)*