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:_____

VALLEY VIEW HEALTH CENTER

Patient Name: _____ **DOB**: _____ **DATE**: _____

Welcome & Thank You for Choosing Valley View Health Center!

Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA). Bring all medications with you to visit.

Please give this document to the Clinical Support Staff when they call you back.

- Does someone have power of attorney or healthcare proxy giving them the power to make decisions about your care in life-threatening situations? ☐Yes ☐No *If yes, please provide VVHC with a copy.*
- Do you have an Advanced Health Directive, such as do not resuscitate? ☐Yes ☐No
- If no, do you want to discuss this with your provider today? ☐Yes ☐No

Medical History: *Please check all that apply.*

☐	Allergies	☐	Cancer	☐	GERD (Heartburn)	☐	Osteoporosis
☐	Anemia	☐	Cardiac Arrhythmia	☐	Headache/migraines	☐	Renal (Kidney) disease
☐	Angina	☐	COPD	☐	Heart disease	☐	Seizure disorder
☐	Anxiety	☐	Coronary Artery disease	☐	Heart Valve Disorder	☐	Stroke
☐	Arthritis	☐	Depression	☐	Hepatitis/Liver disease	☐	Thyroid disease
☐	Asthma	☐	Diabetes	☐	High blood pressure	☐	HIV
☐	Atrial Fibrillation	☐	High cholesterol	☐	Irritable Bowel Disease	☐	Other:
☐	Blood Clots	☐	Gallbladder disease	☐	Myocardial Infarction (Heart attack)		

Operations and/or Hospitalizations: *Please check all that apply.*

☐	Angioplasty	☐	CABG	☐	Gastric Bypass	☐	Uterine Fibroids
☐	Appendectomy	☐	Pacemaker	☐	Hernia Repair	☐	ORIF
☐	Arthroscopy	☐	Carpal Tunnel Release	☐	Hip Replacement	☐	Thyroidectomy
☐	Back Surgery	☐	Cataracts	☐	Hysterectomy	☐	Tonsillectomy
☐	Tubal Ligation	☐	Gallbladder	☐	Knee Replacement		Other:
☐	Blood Transfusion	☐	Colon surgery	☐	LASIK		
☐	Breast Augmentation	☐	D&C	☐	Mastectomy		

- Allow consent to import Medication History (prescribed elsewhere) and HIE documents ☐Yes ☐No
- Have you had any recent specialist or hospital visits? ☐Yes ☐No

Specialists: *A record release form will be given if unable to obtain through HIE. (Electronic Health Information Exchange)*

Specialists Name	

VALLEY VIEW HEALTH CENTER

Patient Name: _____ **DOB:** _____ **DATE:** _____

Family Medical History *Please check all that apply and specify the relationship to you, if they are deceased, and age of death (if applicable).*

Condition	Relationship	Deceased? (Yes/No)	Age of Death?
Alcoholism			
Alzheimer's			
Asthma			
Blood Disorders			
Cancer/ Type:			
Cardiovascular (Heart) Disease			
Coronary Artery Disease			
Coronary Heart Disease			
Depression			
Diabetes			
Hypertension			
Mental Illness			
Migraines			
Osteoporosis			
Renal Disease			
Seizure Disorders			
Stroke			
Thyroid Disease			
Other:			

Over the last 2 weeks how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

- Have you ever felt afraid/threatened/controlled by a partner, family member, or caregiver? ☐Yes ☐No

List Medications

Thank you for answering this comprehensive health history form. Your answers are confidential and will help us provide more complete and knowledgeable care of you.

VALLEY VIEW
HEALTH CENTER

Authorization for Use and Disclosure of Protected Health Information
(Autorización para el uso y la liberación de información servicios de salud protegida)

Patient Name: (Nombre del paciente):_____ DOB (Fecha de nacimiento): _____
Authorization of release from (Autorización de liberación de): _____
Address(Dirección): _____ Phone(Teléfono): _____ Fax: _____

Mail Authorization of Release to(Envíe la autorización de liberación a):
Valley View Health Center
2690 NE Kresky Ave
Chehalis, WA 98532
Phone: 360-330-9595
Fax: 360-330-9530

Please check the Valley View location you are planning to establish with:
(Por favor, revisela ubicación de Valley View con la que planea establecerse):

☐ Chehalis	☐ Centralia	☐ Winlock	☐ Olympia	☐ Onalaska
☐ Pe Ell	☐ Raymond	☐ Tenino	☐ Toledo	☐ Morton
☐ Children's Dental	☐ Centralia Walk-In			

Patient Authorization (Autorización del paciente)**:**
(You may use or disclose of the following healthcare information(check all that apply)):
(Puede utilizar o liberar la siguiente información de atención médica (marque todas las que correspondan)):

☐ Last 2 years of Medical Records (Los últimos 2 años de los registros médicos)
☐ My healthcare information for the date(s)) (Mis datos de atención médica para la(s)fecha(s)):_____
☐ Other (Otros):_ALL MEDICAL RECORDS (TODOS LOS REGISTROS MÉDICOS)

Please Initial (Por favor, inicial):
___HIV (AIDS virus) (VIH (virus del SIDA))
___Psychiatric disorders/mental health (Psiquiatría trastornos/salud mental)
___Sexually transmitted diseases (Enfermedades de transmisión sexual)
___Drug and/or alcohol use (Consumo de drogas y/o alcohol)

Purpose for which disclosure is being made (check one of the following):
(Finalidad por la que se realiza la liberación (marque una de las siguientes opciones)):

☐ Doctor ☐ Transferring Care (Traslado de la atención) ☐ Personal ☐ Attorney (Abogado) ☐ Insurance (Seguro)

My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:
- To take part in a research study; or
- To receive healthcare when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once health care information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it at which time I may no longer be protected under Privacy Laws.

Mis derechos: Entiendo que no tengo que firmar esta autorización para obtener beneficios de atención médica (tratamiento, pago o inscripción). Sin embargo, tengo que firmar un formulario de autorización:
- Para participar en un estudio de investigación; o
- Para recibir atención médica cuando la finalidad es crear información de atención médica para un tercero.

Puedo revocar esta autorización por escrito. Para ver el proceso de revocación de esta autorización, lea el aviso de privacidad para pacientes publicado en el centro en el que se está liberando su información. Entiendo que una vez que la información de atención médica que he autorizado a que se libere llegue al destinatario indicado, esa persona u organización podría volver a liberarla, momento en el cual yo podría dejar de estar protegido en el marco de las Leyes de Privacidad.

SIGNATURE (FIRMA)**:**_____ **DATE** (FECHA)**:**_____
PRINTED NAME (NOMBRE IMPRESO)**:**_____ **Please Check Relationship to Patient** (Por favor, marque la relación con el paciente)**:**

☐Parent (Padre o madre) ☐Self (Uno mismo)☐Legal Guardian (Tutor legal)☐Other(Otro):_____
☐Power of Attorney for health care (Poder notarial para la atención médica)

Attach legal documentation if you are the legal guardian or Power of Attorney for Health Care.(Si es el tutor legal o tiene un poder para atención médica adjunte el documento legal.)

This authorization will expire 90 days from the date signed. (Esta autorización perderá su validez a los 90 días de la fecha de su firma.)