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

MARITAL STATUS:	PREFERRED LANGUAGE:
HOME #:	CELL #:
EMAIL:	EMPLOYER:

APPOINTMENT REMINDERS: ☐ Opt In ☐ Opt Out **(Please note: If you opt out, you are still responsible for attending your appointment and/or notifying your clinic if you need to cancel or reschedule your 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	☐ Spanish Origin	☐ Other:
	☐ Cuban	☐ Mexican	☐ Puerto Rican	☐ Non-Hispanic (Latino)	☐ Decline

VETERAN STATUS: ☐ Yes ☐ No

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

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:

PERSON RESPONSIBLE FOR ACCOUNT ☐ **SELF / PATIENT**

NAME (LAST, FIRST) if other than patient:	DATE OF BIRTH:
RELATION TO PATIENT:	PHONE #:

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

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.

**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

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
☐ Anemia
☐ Angina (chest pain)
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Blood Clots
☐ Cancer
☐ Cardiac Arrhythmia
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ High Cholesterol
☐ Gall Bladder Disease
☐ GERD
☐ Headaches/Migraines
☐ Heart Disease
☐ Heart Valve Disorder
☐ Hepatitis/Liver Disease
☐ High Blood Pressure
☐ HIV
☐ Irritable Bowel Disease
☐ Myocardial Infarction (Heart Attack)
☐ Osteoporosis
☐ Renal (kidney) Disease
☐ Seizure Disorder
☐ Stroke
☐ Thyroid Disease
☐ Other:
☐ No Relevant Past Medical History

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

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

☐ Angioplasty
☐ Appendectomy
☐ Arthroscopy
☐ Back Surgery
☐ Tubal Ligation
☐ Blood Transfusion
☐ Breast Augmentation
☐ CABG
☐ Pacemaker
☐ Carpal Tunnel Release
☐ Cataracts
☐ Gallbladder
☐ Colon Surgery
☐ D&C
☐ Gastric Bypass
☐ Hernia Repair
☐ Hip Replacement
☐ Hysterectomy
☐ Knee Replacement
☐ LASIK
☐ Mastectomy
☐ Uterine Fibroids
☐ ORIF
☐ Thyroidectomy
☐ Tonsillectomy
☐ Other:
☐ No Relevant Surgical History

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

Specialists Name	

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:			
☐ No Relevant Family History ☐ Adopted – No Family History Known			

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

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.

Patient Name: ____ **DOB**: ______________ **DATE**: _______________

Medication List

Please list all your medications here, continue the list on the back of the sheet or create a second sheet if needed. If you have a printed copy of your medication list from your pharmacy or previous primary care office, you may provide us a copy instead.

BRING ALL MEDICATION BOTTLES TO YOUR APPOINTMENT.

Patient's Name:				
Date of Birth:				
Medication Name	**Reason for Taking**	**Date Started**	**Strength**	**Directions (When & How often are you taking?)**

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
- ☐ Mary's Corner

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.)

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)*