

Name: _____

Date of Birth: _____

Email: _____

Please provide us with your identification and your insurance card. No insurance? Ask about our sliding scale.

Name of Insurance: _____ ID: _____ Group: _____

At the walk-in Clinic, we generally evaluate minor injuries and illnesses. We typically evaluate ONE concern per visit. For major or urgent concerns, you may be redirected to the Emergency Room. For evaluation and treatment of general well-being and chronic conditions, you may be redirected to Primary Care.

Please ask to alert reception if you would like to be seen for any of the following:

- Chest pain
- Trouble breathing or new onset shortness of breath
- Trauma- Head injury, Car accident, Fall, Work Injury
- Allergic Reaction
- Bleeding
- Violence- Victim of Assault
- Sexual Assault
- Pregnancy- Concerns regarding current pregnancy (other than confirmation of pregnancy)
- Mental Health- Depression, Anxiety, Trouble Sleeping
- Severe Pain- Headache, Musculoskeletal, Abdominal pain
- Medication Refills

Reason for Visit- Please check only ONE:

- ___ Allergies or Respiratory Illness - Congestion, Earache, Sore Throat, Cough
- ___ Stomach - Nausea, Vomiting, Diarrhea, Constipation, Tenderness or Discomfort
- ___ Urinary - Burning, Urgency, Frequency
- ___ Reproductive - Pregnancy Test
- ___ Genital - Lesions, Rashes or Skin changes, Discharge, Tenderness or Discomfort
- ___ Sexually Transmitted Infection testing, Exposure to Sexually Transmitted Infection
- ___ Skin - Rash or Skin changes, Lesions, Infection, Lumps or Bumps, Ingrown Toenail
- ___ Musculoskeletal - Pain, Tenderness, or Discomfort, not work-related
- ___ Dental Infection- Tenderness or Discomfort, Swelling
- ___ Foreign Body - Skin, Eyes, Ear
- ___ Sports Participation Physical

PATIENT INFORMATION	TODAY'S DATE:
----------------------------	----------------------

LEGAL NAME (LAST, FIRST):	PREFERRED NAME:
---------------------------	-----------------

SOCIAL SECURITY #:	DATE OF BIRTH:
--------------------	----------------

SEX ASSIGNED AT BIRTH: <input type="checkbox"/> Male <input type="checkbox"/> Female	CURRENT GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female
--	---

MAILING ADDRESS:	CITY	STATE	ZIP
------------------	------	-------	-----

PHYSICAL ADDRESS: <i>(*if different from above)</i>	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:

<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Guamanian/Chamorro	<input type="checkbox"/> Samoan
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Korean	<input type="checkbox"/> White
<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Decline

Check all that apply

ETHNICITY:

<input type="checkbox"/> Chicana/o	<input type="checkbox"/> Hispanic (Latino)	<input type="checkbox"/> Mexican American	<input type="checkbox"/> Spanish Origin	<input type="checkbox"/> Other:
<input type="checkbox"/> Cuban	<input type="checkbox"/> Mexican	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Non-Hispanic (Latino)	<input type="checkbox"/> 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:

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 <u>every</u> 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

Print Name

Patient/ Parent / Guardian
Check relationship

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.*

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

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> CABG | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> ORIF |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> LASIK | |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> D&C | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 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.

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)