

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:
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LEGAL NAME (LAST, FIRST):	PREFERRED NAME:
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SOCIAL SECURITY #:	DATE OF BIRTH:
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SEX ASSIGNED AT BIRTH: <input type="checkbox"/> Male <input type="checkbox"/> Female	CURRENT GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female
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MAILING ADDRESS:	CITY	STATE	ZIP
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PHYSICAL ADDRESS: <i>(*if different from above)</i>	CITY	STATE	ZIP
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HOME #:	CELL #:
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EMAIL:	PREFERRED LANGUAGE:
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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: American Indian/Alaskan Native Filipino Other Pacific Islander
 Native Hawaiian Guamanian/Chamorro Samoan
Check all that apply: 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: \$
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RESPONSIBLE PARTY & PARENT/GUARDIAN INFORMATION
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PRIMARY RESPONSIBLE PARTY <i>*Will receive billing statements and primary communication</i> (LAST, FIRST):	DATE OF BIRTH:
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PRIMARY PHONE #:	RELATION TO PATIENT:
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SECONDARY PARENT/GUARDIAN <i>(*if applicable)</i> (LAST, FIRST):	DATE OF BIRTH:
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PRIMARY PHONE #:	RELATION TO PATIENT:
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INSURANCE INFORMATION <input type="checkbox"/> NO INSURANCE / SELF PAY

PRIMARY INSURANCE COMPANY NAME:	SECONDARY INSURANCE COMPANY NAME:
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SUBSCRIBER/POLICY #:	SUBSCRIBER/POLICY #:
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POLICY HOLDER NAME (LAST, FIRST):	POLICY HOLDER NAME (LAST, FIRST):
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DATE OF BIRTH:	DATE OF BIRTH:
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RELATION TO PATIENT:	RELATION TO PATIENT:
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PREFERRED PHARMACY (Name & Location): <input type="checkbox"/> Valley View Health Center Pharmacy <input type="checkbox"/> Other:
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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

<p>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.</p> <p>Authorized Individuals/Emergency Contacts:</p> <p>Name: _____ Phone: _____ Relationship: _____</p> <p>Name: _____ Phone: _____ Relationship: _____</p> <p>Name: _____ Phone: _____ Relationship: _____</p>

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

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 / <i>Nombre</i>	Relationship / <i>Relación</i>

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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Consent given by: _____	VVHC Staff Initials: _____

Welcome & Thank You for Choosing Valley View Health Center!

Patient's Name: _____ **DOB:** _____ **Today's Date:** _____

Please take the time to fill out this form as accurately as possible so we can most appropriately address your child's health needs.

Please give this document to the Medical Assistant or Nurse when they call you back.

PREGNANCY AND BIRTH HISTORY		
Were there any illnesses or problems during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe:
Were there any complications during labor or delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe:
Were any medications used during the pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list:
What type of delivery was performed?	<input type="checkbox"/> Elective C-section <input type="checkbox"/> Emergency C-section <input type="checkbox"/> Normal vaginal	
Time of birth: _____ a.m. or p.m. (please circle one)		

CHILD'S HEALTH HISTORY		
Past Medical History: Please check all that apply		
<input type="checkbox"/> Abuse	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> Alcohol or Substance Abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraines
<input type="checkbox"/> Allergies	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> PTSD
<input type="checkbox"/> Anemia	<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fractures/Broken Bones	<input type="checkbox"/> Sexually Transmitted Infections
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Problem	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Vision Problems
Preventative Health Screenings/Visits		
Date of Last Well Visit:	If not here previous provider:	
Date of Last Dental Visit:	Dental Provider:	
Allergies		
(Please list any allergies to medications and food)		
Vaccinations		
Date of Last Vaccinations:		
Have all your child's vaccinations been in Washington State?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, where else has your child had vaccinations:

Please Provide a Copy of Your Child's Vaccination Records

Current Medications: <i>(Please list all prescription AND non-prescription drugs)</i>		
Pharmacy:		
Medication Name	Dose	Frequency of Use
If you need more room, please list additional medications on back of last page.		

Operations and/or Hospitalizations: <i>(i.e. hysterectomy, mastectomy, tonsillectomy)</i>		
Surgery/Hospitalization	Reason/Diagnosis	Date
If you need more room, please list additional surgical history on the back of the last page.		

FAMILY MEDICAL HISTORY			
Please check all that apply and list family member relationship (and if they are deceased)			
Condition	Relationship	Deceased (Yes/No)	If Deceased, Age at time of Death
Alcoholism			
Alzheimer's			
Asthma			
Blood Disorders			
Cancer/ Type:			
Cardiovascular Disease			
Coronary Heart Disease			
Coronary Artery Disease			
Depression			
Diabetes			
Hypertension			
Mental Illness			
Migraines			
Osteoporosis			
Renal Disease			
Seizure Disorders			
Stroke			
Thyroid Disease			
Other:			

Thank you for answering this preventative 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*)