VALLEY VIEW
HEALTH CENTER

Acknowledgment of Receipt of Statement of Privacy Practices

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Valley View Health Center. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Valley View Health Center reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

Additional Disclosure Authorization		
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. (Personal protected information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Any Member of my family (*i.e. Children, Children's Spouses, Parents, Grandchildren*) (*Name & Relationship*):	**☐YES**	**☐NO**

Person To Contact In Event Of Emergency

Name: _____ Phone: _____ Relationship: _____

Appointment Cancellation Policy

If you are more than **(10) ten minutes** late for your appointment, you **may** be asked to reschedule.
Please provide **at least 24 business hour notice** to cancel or reschedule an appointment.
Appointments cancelled with less than 24 hours' notice will be noted as a "short term cancellation."
If you have **(2) two missed appointments/short term cancellations within (6) six months, you may lose the right to schedule appointments for (6) six months.** Care will still be available for any patients on Standby Status. Standby Status means that a patient must arrive before 8:00 am and wait for an open appointment.
***C**hildren younger than 18 must be accompanied by a parent/guardian who stays at the clinic for the entire appointment. Minors (under 18 years of age) are not allowed to be left in our waiting room without adult supervision.

X_____ _____

SIGNATURE OF PATIENT/GUARDIAN Date

VALLEY VIEW
HEALTH CENTER

Family Size & Income and Patient Financial Responsibility

Patient Name: _____ Date of Birth: _____

Family Size & Income information helps Valley View Health Center meet our grant reporting requirements.

Please people supported by the household income, even if you are not applying for the *discount*.

Name	Relationship to you	Type of income	Monthly gross income
	Self		
		Total income:	

Note: Please include income documentation for everyone listed that has an income. Copies of documents verifying income are required before a *discount* is approved.

☐ Prior year tax return ☐ Two (2) most recent pay stubs ☐ Social Security or Disability Letter ☐ Other _____

If your income is $0, how are you meeting your food, clothing, shelter, and transportation needs?

_____

_____

Discount

It is the policy of Valley View Health Center to provide services regardless of an individual's ability to pay. A *discount* is offered based on family size and annual income.

As a courtesy, we will bill your insurance based on the information you provide us. If you do not have health insurance, we expect you to pay the full balance for services you receive. Payment is required at the time of service, including co-pays, co-insurance, deductibles, service fees, and/or any non-covered services. We accept cash, check/debit cards, and most major credit cards. If you are unable to pay at the time of service, payment arrangements must be made with no additional administrative fees.

If you are unable to pay your bill in full, please contact our Patient Account Specialist at (360) 330-9564 to discuss other resources that may be available to you.

Individual Responsible For Payment ☐ Same as Patient Contact

Name (Last, First, Middle): _____ Date of Birth: _____

Relationship to Patient: _____ SSN: _____

Mailing Address: _____ Phone#: _____

I certify that the Family Size & Income information provided is correct. I give Valley View Health Center permission to verify this information. This form must be completed every 12 months **or** if your financial situation changes.

I hereby authorize the release of all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits of service. I hereby authorize payment directly to Valley View Health Center for services I received. I understand that I am financially responsible to Valley View Health Center for services not paid by insurance or other third-party payers.
I agree to pay the nominal fee or co-payments at every visit.

X _____ _____

SIGNATURE OF PATIENT/GUARDIAN Date