Valley Community Healthcare

Patient Label: _____

# REGISTRATION FORM

| | | |
|---|---|---|
| **Patient's Legal Name:** *(last name, first name, middle initial)* | **Nickname:** *(if different than above)* | |
| **Social Security #:** | **Birth Date:** | **Sex:** ☐ M ☐ F *(birth certificate)* |
| **Gender Identity:** ☐ Female ☐ Male ☐ FTM/Transgender Male ☐ MTF/Transgender Female ☐ Genderqueer ☐ Choose Not To Disclose ☐ Other, please specify: _____ | | |
| **Sexual Orientation:** ☐ Straight/Heterosexual ☐ Bisexual ☐ Lesbian/Gay/Homosexual ☐ Don't Know ☐ Choose Not To Disclose ☐ Other, please specify: _____ | | |
| **Preferred Pronoun:** ☐ She, Her, Hers ☐ He, Him, His ☐ They, Them, Theirs ☐ Ze, Hir ☐ Asked, but Unknown ☐ Declined to Answer ☐ Other | | |
| **Street Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Life Partner ☐ Same Sex Couple ☐ Unknown | **Mother's Maiden Name:** *(first and last)* | |
| **Student Status:** ☐ Not a student ☐ Full time ☐ Part time | **Preferred Language:** ☐ English ☐ Spanish ☐ Other, please specify: _____ | |
| **Primary Phone:** | **Cell Phone:** | **Email:** |
| **Current School:** | | |
| **Do you need an interpreter?** ☐ Yes ☐ No | **Do you use a TTY?** *(text telephone)* ☐ Yes ☐ No | |
| **Do you have any contact restriction?** ☐ Confidential – Do Not Contact ☐ Other: _____ ☐ Phone – Do Not Identify as VCH | ☐ Teen Patient DO NOT CONTACT PARENT – SENSITIVE SERVICES | |
| **What is your current housing situation?** *(mark one)* ☐ Not Homeless ☐ Living with Friends ☐ Homeless Shelter ☐ Street ☐ Transitional ☐ Permanent Supportive Housing ☐ Other ☐ Decline to State | | |
| **Are you a migrant or seasonal farm worker?** ☐ Yes ☐ No | | |
| **What is your race?** *Check one or more*: ☐ Asian ☐ Filipino ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaskan Native ☐ White ☐ Decline to State | | |
| **Do you consider yourself Hispanic or Latino/a?** ☐ Hispanic or Latino/a ☐ Non-Hispanic or Latino/a ☐ Decline to State | **Are you a veteran?** ☐ Yes ☐ No | |
| **Emergency Contact 1:** Name: | **Phone #:** | **Relationship:** |
| **Emergency Contact 2:** Name: | **Phone #:** | **Relationship:** |
| **Confidential Contact:** Name: | **Phone #:** | **Relationship:** |

_____ _____

Patient/Parent/Guardian Signature Date

Valley Community Healthcare

Patient Label: _____

| Primary Care Only - GUARANTOR | | | |
|---|---|---|---|
| **Name:** | | **Social Security #:** | **Date of Birth:** |
| **Relationship:** | **Address:** | | **Phone #:** |
| **Income:** | ☐ **Annually** ☐ **Monthly** ☐ **Weekly** ☐ **2 Weeks** ☐ **Other** | | **Number in Family:** |
| **Do you currently have any type of health care coverage?** ☐ Yes ☐ No | | | |

Valley Community Healthcare is dedicated to providing our patients with the highest quality health care, regardless of coverage. To be able to do this, it is important that you provide us with accurate and true information. We use this information to identify you and determine your eligibility, and complete claims for various health care programs. This information helps us determine if these programs cover the services and supplies you receive.

Many insurance companies, including Medicare, require a co-payment and/or deductible payment from the patient. You are responsible for these payments and will be billed. If you do not provide Valley Community Healthcare with accurate and true information, payment of your services may be denied and you will be financially responsible for all charges.

I certify and declare under penalty of perjury, under the laws of the State of California, that I understand this form and that the information provided is true, correct and complete.

Patient Name: _____ Date: _____

Responsible Relative Signature: _____ Relationship: _____

***Please do not write below this point.***

**Registered by: _____ Date: _____**

Valley Community Healthcare

# General Patient Consent to Treatment and

# Acknowledgement of Clinic Policies, Services, and Confidentiality

This form has information for all Valley Community Healthcare (VCH) patients so that you have the best healthcare experience by knowing what to expect. Please let us know if you would like a copy of this form to keep or it can be downloaded at www.vchcare.org.

**How We Provide Your Care**

Medical care at VCH is provided by doctors (medical, optometry and dental), mid-level providers, and/or other professionals. Mental Health and substance abuse counseling services are available with VCH Behavioral Health providers. If VCH cannot provide all the care a patient needs, we will make proper referrals for further treatment.

**Patient Rights and Responsibilities**

As a VCH patient, you have certain rights and responsibilities, which are listed on this form. Please contact the clinic manager if you have any questions.

VCH employees are never allowed to force or pressure any patient into: receiving any service; participate in any sexual activity; use any form of birth control; or, use any medication against their will., It is illegal for a healthcare provider to be involved with, or try to be involved in an intimate or sexual relationship with patients or former patients.

Public intoxication or being high is a crime and is NOT permitted at any VCH location. Intoxicated or high patients will be asked to reschedule their visit.. Inappropriate behavior is not allowed. Patients making verbal/physical threats, sexual advances, or rude comments to VCH staff or other patients may have their services stopped at VCH

Per CA Labor Code, all VCH sites are non-smoking areas.

Patients are expected to arrive at the front desk between 15-20 minutes before their appointment time for check-in and to fill out paperwork needed for their visit. It is the responsibility of patients to cancel 24 hours ahead of their scheduled visit if they are not able to attend. Failure to show for appointments or meet our attendance policies may result in re-scheduled appointments, or being limited to same day or wait list visits only.

**Non-Discrimination in Services**

When providing healthcare services, VCH does not discriminate because of race, ancestry, national origin, ethnic identity, color, medical condition, disability (including AIDS), age, veteran status, gender identity, sex, religion, marital status, sexual orientation, genetic information, political views, party affiliations or ability to pay for services. VCH has interpreter services during business hours for non English- speaking patients and deaf/hard-of-hearing patients. In order to care for patient needs, most VCH staff speak both English and Spanish. VCH also provides written information in Spanish.

**Minor Consent Rights**

Patients/guardians of patients under 18 are responsible for coming with their children to their appointments and to give consent for services, unless stated by law or in writing by parent/guardian. Minors age 12 and over may sign for sensitive medical services without parental permission and/or consent. Minors are encouraged to involve their parents/guardians or caring adult in all of their health care.

**What We Must Report**

VCH by law must report suspected rape, child/elder/dependent adult abuse, and domestic violence. In addition, California Healthcare providers must report if he or she "reasonably suspects the patient is suffering from any wound or physical injury as the results of assault or abusive conduct". Federal law requires providers to notify the patient if a report is being filed unless this places the patient at risk or it is against the patient's best interest to notify them. VCH staff will provide support to patients and make the safety and well-being of the patient, and any involved dependents, our top priority.

VCH must report any positive tests of communicable diseases (like Tuberculosis, COVID-19, Chlamydia, HIV, Syphilis) to the Los Angeles County Department of Health Services.

**Confidentiality of Patient Information**

To offer our patients our best service, VCH needs the most up-to-date contact and identification information. The patient should bring a list of current medications, and medical records with the most up to date health information, to their first visit and every appointment.

VCH is required to protect the Personal Health Information (PHI) of our patients in all areas. The law allows VCH to use PHI for normal business activities including treatment, payment, healthcare operations, for the purpose of personal safety or as needed by your insurance. VCH will not release, sell, or use your PHI except as stated. VCH will not release your PHI to your employer without your written approval, unless required by law. If any patients are unable to give consent, there are rules to protect your rights that allow your legal representative or guardian to give consent for you. Under the Health Insurance Portability and Accountability Act (HIPAA), patients have these rights regarding their PHI:

1. The right to request how PHI is given to them.
2. The right to access, inspect, and/or get a copy of PHI (within a certain time).
3. The right to ask that VCH restrict use or disclosure of PHI (in certain situations). VCH does not have to agree to requests; all requests are looked at as required under HIPAA.
4. The right to ask that VCH change incorrect or incomplete PHI maintained by VCH. VCH may deny the request for changes in certain situations.
5. The right to receive a list of times when we may have shared your PHI (for more information, contact the Risk Manager or Chief Operating Officer).

**Financial Responsibility and Coverage**

VCH uses a sliding fee discount scale for patients who have no other forms of medical coverage and meet eligibility criteria. All patients who want to be screened for a sliding fee discount are required to provide proof of household income at registration and then each year. If you do not provide proof of income, you will not be able to be screened to possibly receive discounted services. Patients who do not

want a discount do not have to present proof of income. The Federal Poverty Level guidelines, updated every year, are used to calculate the amount of the discount. Patients who are at 251% of the poverty level or above will not receive a discount on charges. Patients who are at 100% of the poverty level or below receive a 100% discount and are charged a nominal fee for their exam. Patients may be charged for additional services received like supplies, medications, and immunizations, provided during or as a result of the visit. All patients without insurance are screened for enrollment in MediCal or other programs. If eligible, patients are asked to apply for those programs. Patients are expected to pay any co-pays, nominal fees or share of cost on the day of service. If the patient has current medical coverage (ex. Private insurance, Medicare, MediCal, etc.) proof of this must be brought to each visit for VCH to verify. No patient will be turned away due to lack of ability to pay.

**Patient Complaint and Grievance Procedures**

VCH follows policies and procedures approved by our Board of Directors to handle patient complaints and grievances. Patients can expect their complaint to be acknowledged within three (3) business days of receipt. Complaints will be fully investigated within a timely manner with the goal of resolving the issue to the fullest extent possible. Complaints about VCH services, facilities or discrimination may be filed in writing via mail (Risk Manager, 6801 Coldwater Canyon Avenue, North Hollywood, CA 91605, dropped off in person at that address, or faxed to (818)763-7231. If you have a complaint about how your PHI was used and/or disclosed, you may file a complaint at any time; the outcome will be sent to you in writing according to VCH policy. A complete copy of the VCH Privacy Notice is posted on clinic property. For a personal copy, ask the reception desk staff, or see our website at www.vchcare.org. Patients with complaints or grievances involving the County of Los Angeles may contact the Department of Health Services at (213)240-8101. If you feel unhappy with the resolution of services provided by VCH, patients may direct their claim to the Director of the Department of Health Services.

**Patient Acceptance and Authorization**

By reading and signing this form, I accept my rights and responsibilities as a patient and consent to receive treatment and services provided by VCH. I accept full responsibility for all charges whether or not they are covered by insurance. I allow VCH to release any information requested by my insurance company in order to make payments to VCH as well as to other third parties as permitted by law and in accordance with HIPAA guidelines so long it is necessary for my health care and or to further advance my well-being. I have read and understand the above information and give authorization for payment of insurance benefits to be made directly to VCH for services rendered.

_____ _____ _____

Patient/Guardian Signature Printed Name Date

_____

Witness Signature