Chart # _____ / EE Initials _____

PATIENT REGISTRATION

Patient Information **(Please print clearly)** Name must match what is on your insurance card(s) or we may not be able to bill.

Last Name: _____ **First:** _____ **MI:** _____

Preferred Name: _____ **Birthdate**: _____ **Sex at Birth**: ❑F ❑M **SSN** _____

Marital Status: ❑S ❑M ❑D ❑W ❑SEP **Email Address**: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Physical Address (if different): _____ City: _____ ST: _____ Zip: _____

Cell Phone #: _____ **Can we contact you via text?** ❑Yes ❑No **Leave Voice Message?:** ❑Yes ❑No

Alternate Phone # (if applicable): _____ ❑Home Landline ❑Work ❑Message Phone

Emergency Contact: _____ **Phone:** _____

Relationship: _____ **Does this person know that you are a patient at Hill Country?** ❑Yes ❑No

Parent or Legal Guardian(s) - *(if patient is minor)*

Is there a legal custody agreement in place for this minor? ❑Yes ❑No *(if yes, please provide a copy for our records)*

Parent/Guardian Name:		Parent/Guardian Name:	
Date of Birth:		Date of Birth:	
Relationship to Minor:		Relationship to Minor:	
Address:		Address:	
Phone number:		Phone number:	

Patient Demographics: ***WHY DOES HILL COUNTRY ASK FOR THIS INFORMATION?*** To enable us to qualify for our grants and meet our Federal and State reporting requirements, along with possibly allowing us to offer more services, we must ask for the following information. Your answers are strictly confidential. Your name will not be used. Please check the appropriate box.

Language at home:	❑English ❑Spanish ❑Other: _____
Race: (Check all that apply)	❑White ❑Black/African American ❑Native Hawaiian ❑Other Pacific Islander ❑Asian Indian ❑Chinese ❑American Indian/Alaskan Native ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Other Asian ❑Samoan ❑Guamanian or Chamorro ❑More than one race ❑Choose not to disclose race
Ethnicity:	❑Not Hispanic, Latino/a or Spanish Origin ❑Puerto Rican ❑Mexican, Mexican American, Chicano/ ❑Another Hispanic, Latino/a, or Spanish Origin ❑Cuban ❑ Choose not to disclose ethnicity
Sexual Orientation:	❑ Lesbian or Gay ❑Heterosexual (straight) ❑Bisexual ❑Don't Know ❑Choose not to disclose ❑Other
Gender Identity:	❑ Male ❑Female ❑Choose Not To Disclose ❑Transgender Man/Transgender Male/Transmasculine ❑Transgender Woman/Transgender Female/Transfeminine ❑Other

Are you a Veteran?: ❑Yes ❑No	**Agricultural (Farm) Worker?:** ❑Yes ❑No **If yes, are you:** ❑Seasonal ❑Migrant
Homeless: ❑No ❑**Yes** →	**IF HOMELESS, currently living in:** ❑Homeless shelter ❑Transitional Housing ❑Doubled Up ❑Street ❑Permanent supportive housing ❑Other

Family Size: _____ **What is your Average Monthly Income:** _____ **❑Declined to provide information**

The preceding information is true to the best of my knowledge:

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Chart # _____ / EE Initials _____

PATIENT CONSENTS

Consent for Medical/Dental/Behavioral Health Treatment

Patient Name:_____ **Date of Birth:** _____

ADULT: I hereby authorize Hill Country Community Clinic and all persons acting as agents thereof, as well as all medical/dental personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic, medical / dental / behavioral health treatment to me.

If MINOR: I, as the parent/guardian (circle one) of the above named minor, hereby authorize Hill Country Community Clinic medical/dental personnel to whom said minor is referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic, medical / dental / behavioral health treatment to said minor. This consent shall remain in force until a written revocation is filed at the clinic.

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law.

Our Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to provide you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this Notice.

Patient Acknowledgement of Receipt/Opt Out

☐ **I have been provided a copy of the health center's Notice of Privacy Practices**

☐ **I have been offered, but have chosen not to receive copy of the health center's Notice of Privacy Practices**

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Chart # _____ / EE Initials _____

FINANCIAL AGREEMENT / MEDICAL & DENTAL INSURANCE POLICIES

Primary MEDICAL Insurance / ❑ NONE

ID#: _____ **Group #:** _____	❑Medicare ❑AARP Medicare Advantage Secure Horizons PPO (HMO plan *NOT* accepted) ❑Partnership / Medi-Cal ❑Anthem Blue Cross ❑Blue Shield ❑Aetna ❑Cigna ❑United Healthcare ❑Tri-West/Tricare ❑OTHER: _____

Is the Patient the Primary Insured / Policyholder: **YES / NO**

IF NO, please provide the following information about the primary policy holder:

Relationship to patient (circle one): SPOUSE / PARENT

Name:_____ DOB: _____ SSN: _____ Sex: ❑F ❑M

Secondary MEDICAL Insurance / ❑ NONE

ID#: _____ **Group #:** _____	❑Medicare ❑AARP Medicare Advantage Secure Horizons PPO (HMO plan *NOT* accepted) ❑Partnership / Medi-Cal ❑Anthem Blue Cross ❑Blue Shield ❑Aetna ❑Cigna ❑United Healthcare ❑Tri-West/Tricare ❑OTHER: _____

Is the Patient the Primary Insured / Policyholder: **YES / NO**

IF NO, please provide the following information about the primary policy holder:

Relationship to patient (circle one): SPOUSE / PARENT

Name:_____ DOB: _____ SSN: _____ Sex: ❑F ❑M

DENTAL Insurance / ❑ NONE

ID#: _____ **Group #:** _____	❑ Partnership / Medi-Cal ❑Delta ❑Humana ❑Anthem Blue Cross ❑Cypress Care ❑Blue Shield ❑OTHER: _____

Is the Patient the Primary Insured / Policyholder: **YES / NO**

IF NO, please provide the following information about the primary policy holder:

Relationship to patient (circle one): SPOUSE / PARENT

Name:_____ DOB: _____ SSN: _____ Sex: ❑F ❑M

PLEASE PROVIDE YOUR PRESCRIPTION COVERAGE CARD IF DIFFERENT FROM THE INFORMATION PROVIDED ABOVE

Chart # _____ / EE Initials _____

Payment and Billing Policy

- **You are responsible for all charges incurred on your account.** Payment is expected at time of service for fees that have been determined to be the responsibility of the patient.
- **Medi-Cal/CMSP/Partnership:** Hill Country accepts Medi-Cal, CMSP, and Partnership. A current card must be presented at each visit.
- **Medicare:** We are required to collect additional information to determine coverage.
- **Insurance Plan:** We are contracted with many but not all insurance carriers. If we don't appear on your insurance carriers provider list this may affect how your insurance plan pays for your care and you may be required to pay at time of service.
- **Payment Methods:** Hill Country Community Clinic accepts cash, personal checks, debit cards, Visa and MasterCard. A $10.00 service fee will be charged for bounced checks.

A sliding fee discount is available for qualifying patients who are unable to afford care

- I hereby authorize the release of any and all information acquired in the course of my examination/treatment as required by my insurance carrier.
- I hereby authorize and request the payment of benefits be sent directly to Hill Country Community Clinic for services rendered.
- These assignments will remain in effect until revoked by me in writing. A copy of this agreement is considered as valid as the original.

I have read the above Patient Financial Agreement and agree by signing below:

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Chart # _____ / EE Initials _____

SLIDING FEE DISCOUNT PROGRAM

You may qualify for a discount on services provided by Hill Country Health & Wellness Center even if you have insurance, Medicare, or Medi-CAL. To Apply – Please provide the requested information below, sign and date.

Please list yourself and any other person(s) living in your household that you are financially responsible for **and** the total income (before taxes) for each person (do not include food stamps or other non-cash income). ***This information helps Hill Country continue to provide grant funded services to our patients.***

ID# (Office Use)	Full Name	Date of Birth	Monthly Gross Income

☐ **I am not eligible for this program. My household income exceeds 200% of poverty level (please see back of form for reference).**

☐ **I Decline. I prefer not to participate in this program. I understand that services not covered by my insurance may be billed to me without discount.**

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

If you are eligible, the discount will be valid for one year from the effective date.

See our handout **Sliding Fee Discounts at HCHWC** for program details.

Office Use Only ☐ Refused / Declined (must have signature above)

Household size: _____ Total Monthly Income: _____

Discount Level: A B C D E (not eligible/over income) _____% FPG

Reviewed by (date/initial): _____&_____ Scanned: _____

Application Effective Date: _____ Renewal Date: _____

Chart # _____ / EE Initials _____

Unsure if you exceed 200% of poverty?

Please review the tiers below. If your income is higher than the income example furthest to the right, you may not qualify. If you have questions, please ask our front office staff. Thank you.

Monthly Income

Level D 171 - 200%			
Family Size	Family Income		
1	1,926	to	2,265
2	2,595	to	3,052
3	3,264	to	3,838
4	3,932	to	4,625
5	4,601	to	5,412
6	5,270	to	6,198
7	5,938	to	6,985
8	6,607	to	7,772
9	7,276	to	8,558
10	7,944	to	9,345
11	8,613	to	10,132
12	9,282	to	10,918
For larger households add	*787 per Household Member*		
Behavioral Health			$ 25
Medical			$ 40
Dental			$ 60

Annual Income

Level D 171 - 200%			
Household Size	Household Income		
1	23,104	to	27,180
2	31,128	to	36,620
3	39,152	to	46,060
4	47,176	to	55,500
5	55,200	to	64,940
6	63,224	to	74,380
7	71,248	to	83,820
8	79,272	to	93,260
9	87,296	to	102,700
10	95,320	to	112,140
11	103,344	to	121,580
12	111,368	to	131,020
For larger households add	*9,440 per Household Member*		
Behavioral Health			$ 25
Medical			$ 40
Dental			$ 60

Chart # _____ / EE Initials _____

ADDITIONAL CONSENTS OR DISCLOSURES

Patient Consent for the Release of Information on Voicemail or Answering Machine

I, _____ , give my permission for the following normal result information: lab results, pap test results, pathology reports, x-ray results, and referrals, prescriptions, and appointment information to be left on the voicemail/answering machine of any phone numbers I provide to Hill Country Community Clinic to contact me.

I understand I also have the option to review or request some of this information via the Patient Portal.

This authorization is effective until rescinded by myself in writing.

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

IF PATIENT IS A MINOR (optional):

Parental Delegation of Authority to Seek Health Care Services for Minor Dependent

I, _____ _____ of
Name of Parent or Legal Guardian — Relationship to Minor

_____ _____ give authorization for:
Minor Patient Name — Minor's Date of Birth

_____ _____
Print Name — Relationship to Parent/Guardian

_____ _____
Print Name — Relationship to Parent/Guardian

_____ _____
Print Name — Relationship to Parent/Guardian

to bring Minor to **Hill Country Community Clinic** for medical, behavioral health, and/or dental treatment in the event that I am unavailable to do so. **This authorization is effective until rescinded by myself in writing.**

PARENT / LEGAL GUARDIAN SIGNATURE:	►	**DATE:**

Chart # _____ / EE Initials _____

Patient Consent to Obtain Medication History

As a user of an electronic medical record, your Hill Country provider would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

An accurate medication history is **very important** to help us treat you and to avoid potentially dangerous drug interactions.

Your medication history might not include over the counter medicines, supplements or herbal remedies. **It is still very important for us to take the time to discuss everything you are taking,** and for you to tell us about any errors in your medication history.

Please initial your choice and sign below.

_____ **I give permission** for Hill Country Health and Wellness Center to obtain my medication history from my pharmacy, my health insurance (including state and federal benefits programs) and any other healthcare providers or drug and alcohol treatment programs. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

OR

_____**I DO NOT give permission for** Hill Country Health and Wellness Center to obtain my medication history from my pharmacy, my health insurance nor my other healthcare providers.

By signing this consent form without making a selection, you are consenting to giving permission to Hill Country Community Clinic to obtain medication history from locations stated above.

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Conflict of Interest Disclosure

If there is anyone employed at Hill Country Community Clinic that you do not want to have access to your medical, dental, or behavioral health records, please list their names and the reason why:

1. _____
   _____
2. _____
   _____

A representative from our office may contact you for more information. All information disclosed is kept confidential and used only to keep your personal information secure

Chart # _____ / EE Initials _____

Authorization for use or Disclosure of Health Information from Hill Country to Spouse/Relative/Friend

Name of Patient:_____ **Birth date:** _____

The Person named above authorizes the following information to be requested or released by representatives of Hill Country Health and Wellness.

I hereby authorize **Hill Country Health & Wellness Center** **to discuss <u>your</u> patient information with:**

	Name	Relationship	Phone
1.			
2.			

To Specify Records: Check the box and initial to specify which type of information is to be released.

☐ **ALL health information pertaining to my medical history, physical condition and/or treatment.** _____ **Initial**

OR

Only the following records or types of health information (specify & include dates).

- ☐ **<u>Appointment times and scheduling</u>**
- ☐ Immunization records
- ☐ Recent and current problem list
- ☐ Recent and current medication list
- ☐ Lab results from _____to_____
- ☐ X-ray/imaging/ diagnostic reports from_____
- ☐ Other_____

I <u>specifically</u> authorize release of the following information (initial as appropriate):

- ☐ Mental health treatment information _____ initial
- ☐ HIV and STD test results _____ initial
- ☐ Alcohol/drug treatment information _____ initial

<u>DURATION:</u>
This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here. _____

TO CANCEL THIS AUTHORIZATION:
You or your representative can cancel this authorization upon written request. If you cancel this authorization, it will not affect information disclosed before the receipt of written request.

<u>MY RIGHTS:</u>

- You have the right to inspect the information you are authorizing to be released (**excludes "psychotherapy notes" as defined in CFR 164.501**).This and other specific rights regarding the handling of your health information are outlined in the Hill Country Health and Wellness' Notice of Privacy Practices.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. Hill Country Health and Wellness is not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits.
- You have the right to receive a copy of this authorization.

PATIENT / PARENT / LEGAL GUARDIAN OR REPRESENTATIVE SIGNATURE:	►	**DATE:**

If signed by someone other than patient, indicate relationship:_____

THIS PAGE INTENTIONALLY LEFT BLANK

Chart # _____ / EE Initials _____

HILL COUNTRY HEALTH AND WELLNESS CENTER SHARED HEALTH INFORMATION PROTECTION POLICY & INFORMED CONSENT

Hill Country's Electronic Health Record system enables our team of health care providers and staff to efficiently share patient information with each other, which means better communication between all of your providers and more comprehensive care for you. **Our goal is to provide you the best possible care, which means that your medical, dental and behavioral health providers will all have access to certain information about your health and treatment.**

Hill Country also shares your health information using the regional Health Information Exchange, SacValley Med Share. This important feature allows your doctors at other locations (such as hospitals and emergency rooms) to quickly access to your health records even when our offices are closed. Hill Country and SacValley MedShare use the highest standards to ensure the safety and privacy of your records in this process. For more information about SacValley MedShare see their website at **http://sacvalleyms.org/**

These are the items that will be shared:

Hill Country Providers <u>Only</u>	**SacValley MedShare (HIE)**
• Physical and Mental health conditions, history, including symptoms and diagnoses, prognoses	• Allergies, Adverse Reactions
• Treatment goals and plan, including medications and other recommendations	• Problems list
• Results of test or other evaluations used to diagnose or develop interventions	• Medications list
• Specific concerns about your health, safety or emergency needs	• Vitals Signs
• Follow up plan, including referrals for other care types or specialties	• Encounter codes and procedure codes
• Updates regarding your health status, functioning, participation and progress	• Lab Results

IMPORTANT NOTE ABOUT BEHAVIORAL HEALTH INFORMATION: Other than the information listed above, the specific contents and analysis of conversations between you and your therapist during a psychotherapy session is **<u>not</u>** shared. This information has special protection under the law and a separate consent form must be signed by you before such information can be shared.

You will be automatically enrolled in SacValley MedShare upon the creation of your chart. To OPT OUT of SacValley MedShare, please visit the following website for an opt-out form:

English: https://sacvalleyms.org/wp-content/uploads/2024/06/SVMS-FORM-002-006-Opt-OutForm.pdf
Spanish: https://sacvalleyms.org/wp-content/uploads/2024/06/SVMS-FORM-002-006-Opt-OutForm-Spanish.pdf

Patients must submit their own opt-out forms if they do not wish to participate

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Chart # _____ / EE Initials _____

Hill Country No Show Policy

As of June 1, 2023

What is a "No Show"?

A patient is a "no-show" if they miss their appointment AND do not let the clinic know at least two hours before.

Medical

Patients who “no show” two medical appointments in six months can only get care by on a walk-in basis in for six months.

Dental

Patients who “no show” two dental appointments in six months can only get care by on a walk-in basis in for six months.

Behavioral Health

Patients who “no-show” three behavioral health appointments in a row will need to call to be put back on the waitlist.

What does 'Walk-In Basis' Mean?

In Medical and Dental, patients will get suggested times to come to the clinic in case another patient doesn’t show up. There’s no guarantee you’ll be seen that day, and you might need to come back on other days.

What Happens Next?

For Medical and Dental, patients will remain on “walk-in basis” for six months but must have at least one completed visit before they can schedule appointments. For behavioral health, patients must wait on the list until it is their turn and a provider has an opening.

Questions?

Call 530-337-5757

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Chart # _____ / EE Initials _____

PATIENT HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

Allergies: _____

_____

Current Medication List: _____

_____

_____

PHARMACY: _____

Past or Current Medical History – Check all that apply

□ Allergies_____

□ Anxiety_____

□ Arthritis_____

□ Arthritis, Rheumatoid_____

□ Asthma _____

□ Atrial Fibrillation_____

□ Anemia_____

□ Bleeding Disorders_____

□ Bladder Problems_____

□ Coronary Artery Disease_____

□ Chronic Obstructive Pulmonary Disease (COPD)

_____

□ Cancer_____

□ Congestive Heart Failure (CHF)_____

□ Diabetes_____

□ Depression_____

□ Eyesight Problems_____

□ Gallbladder Disease_____

□ Gastric Ulcer_____

□ GERD_____

□ Gout_____

□ Hearing Loss_____

□ Hepatitis_____

□ HIV Infection_____

□ Hyperlipidemia (High Cholesterol)_____

□ Hypertension (High Blood Pressure)_____

□ Hypothyroidism_____

□ Aortic Aneurysm_____

□ Insomnia_____

□ Low Back Pain_____

□ Migraine Headaches_____

□ Obesity_____

□ Osteoarthritis_____

□ Osteoporosis_____

□ Peripheral Vascular Disease_____

□ Psychiatric Disorders_____

□ Seizure Disorders_____

□ Sleep Apnea_____

□ Venereal Diseases_____

□ Pregnancies #_____ □ Children # _____

Surgical History

□ Cholecystectomy (gallbladder removal)_____

Eye Ear Nose Throat

□ Gastric Surgery_____

□ Cataract_____

□ Hernia Repair_____

□ Thyroid Surgery_____

□ Ulcer Surgery_____

Chart # _____ / EE Initials _____

□ Tonsillectomy_____

□ Adenoidectomy_____

□ Ear Surgery_____

Cardiovascular Surgery

□ Aortic Aneurysm_____

□ Angioplasty_____

□ CABG_____

□ Heart Valve_____

□ Cardiac Stent_____

□ Vascular Surgery_____

Breast Surgery

□ Mastectomy_____

□ Lumpectomy_____

□ Augmentation _____

Gastrointestinal Surgery

□ Abdominal Surgery_____

□ Appendectomy_____

□ Laparoscopy_____

□ Pancreatic Surgery_____

□ Skin Surgery_____

Orthopedic Surgery

□ Joint Surgery_____

□ Carpal Tunnel_____

□ Back Surgery_____

□ Other_____

_____

GYN/GU Surgeries

□ Cesarean (C-section)_____

□ Hysterectomy_____

□ Tubal Ligation_____

□ Vasectomy_____

□ Bladder Surgery_____

□ Prostate Surgery_____

□ Kidney Surgery _____

Other Disorders or Diagnosis that you have been given by any doctor _____

_____

_____

ER or Urgent Care (Recent): _____

Previous Hospitalizations: *(Please list details, such as, reason, year, facility, etc.)* _____

_____

_____

_____

Social History: Alcohol: Type _____ How much/often?_____

Caffeine: Type_____How much/often?_____

Tobacco: Type _____ How much/often?_____

Street Drugs: Type _____How often?_____

Exercise: Type_____How much/often?_____

Special Dietary Needs:_____

Work History: Type of Work_____ Full Time / Part Time / Retired / Disabled
(Circle one of the above)

Chart # _____ / EE Initials _____

Family History: Mother: Age:_____ *Living or Deceased*

If deceased, cause of death: _____

Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Father: Age:_____ *Living or Deceased*

If deceased, cause of death: _____

Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Brother(s): Age:_____ *Living or Deceased*

If deceased, cause of death: _____

Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Sister(s): Age:_____ *Living or Deceased*

If deceased, cause of death: _____

Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Other Pertinent Family History: _____

_____

_____

List Routine Care by Other Doctors/Specialists/Hospitals:

_____

_____

Recent Health Maintenance:

- □ Pap Smear: Year _____ Results_____
- □ Mammogram Year _____ Results_____
- □ Colonoscopy Year _____ Results_____
- □ Cholesterol Screen Year _____ Results_____
- □ Pneumonia Shot Year _____
- □ Tetanus: Tdap, Td Year _____

Chart # _____ / EE Initials _____

Additional Medical Health History Information: