CommuniCare HEALTH CENTERS

Place Patient Label Here

PATIENT REGISTRATION AND CONSENT

Preferred Name			
Last Name	First Name	MI	Date of Birth
Mailing Address	City	State	Zip Code
Street Address	City	State	Zip Code

Home Phone	Cell Phone	**Ok to send text messages?**
		☐ Yes ☐ No

What sex were you assigned at birth? (Check one):
☐ Female ☐ Male ☐ Decline to state
☐ Additional category (Please specify): _____

What pronoun do you use? (Check one):
☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Decline to state
☐ Additional category (Please specify): _____

What is your sexual orientation? (Select all that apply):
☐ Straight or Heterosexual ☐ Queer ☐ Don't know
☐ Lesbian or Gay ☐ Bisexual ☐ Decline to state
☐ Additional category (Please specify):

What is your current gender identity? (Check all that apply):
☐ Male ☐ Transgender Male/Transman/FTM ☐ Genderqueer
☐ Female ☐ Transgender Female/Transwoman/MTF ☐ Decline to state
☐ Additional category (Please specify): _____

Marital Status (check one):
☐ Divorced
☐ Married
☐ Partnered
☐ Single
☐ Widowed
☐ Legally Separated

Emergency Contact (Please print "none" below, if you do not have an emergency contact):

Last Name	First Name
Relationship to patient	Phone Number

Insurance Type (check one):
☐ MediCal/Partnership ☐ Private Insurance ☐ Covered California ☐ Medicare ☐ None
☐ Other (please specify): _____

Social Security Number	Email Address

Race (Check all that apply):
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White
☐ Decline to state

What is your ethnicity? (Check one):
☐ Hispanic/Latino ☐ Not Hispanic/Latino

What is your Primary Language?

Do you need a translator for your visit?
☐ Yes ☐ No

What pharmacy would you like us to send your medication to?

For patients under 18, Parent or Legal Guardian Information:

Last Name	First Name	Date of Birth	Phone Number

Additional Patient Information (Please answer ALL questions)

CommuniCare is a non-profit. By answering these questions, you will give us information needed to acquire grant funds that help uninsured and underinsured people in our community. Please help us serve you and our community by providing us with this information. This information will become a part of your confidential medical record.

Are you disabled?
☐ Yes ☐ No

Are you a Veteran?
☐ Yes ☐ No

Where are you currently living? (Check all that apply):
☐ Home/Apartment ☐ Outside (Street/Car)
☐ Shelter ☐ Staying with friends/family
☐ Transitional Housing ☐ Other: _____

Are you a seasonal/migrant agricultural worker? (Check all that apply):
☐ Seasonal agricultural worker: my main job is agriculture and I don't work year-round
☐ Migrant agricultural worker: my main job is agriculture and I move to find my jobs

How many people are in your household?

How much income did everyone in your house get last month before taxes?

PLEASE TURN OVER AND CONTINUE ON THE BACK

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CONSENTS

To provide treatment, bill your insurance, or release information required by your insurance carrier, etc., we must receive your consent by initialing the areas indicated and by providing your signature below.

Assignment of Benefits: I assign to CommuniCare Health Centers (CCHC) all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by CCHC. _____(initials)

Consent of Treatment: I authorize CCHC and its medical, nursing, and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of CCHC's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by CCHC personnel. _____(initials)

Consent to Telehealth: Telehealth involves the use of audio, video, or other electronic communications to interact with patients, consult with healthcare providers and/or review medical information for the purpose of diagnosis, therapy, follow-up and/or education. During a telehealth visit, details of my medical history and personal health information may be discussed with other health professionals using interactive video, audio, and telecommunications technology. Additionally, a physical examination may take place and video, audio, and/or photo recordings may be taken. The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. I authorize CCHC and its medical, nursing, and other professional staff members, to provide telehealth care services if it is advisable in my care. _____(initals)

Transportation Assistance: I understand that transportation for Medi-Cal beneficiaries is available for in-person visits if I am having trouble traveling to and from my appointments. _____(initals)

Patient Acknowledgement: I acknowledge receiving notice that under federal law relating to the operation of health centers, the Federal Tort Claims Act (FTCA) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions within the scope of any clinic volunteer or employee health practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. (See Public Health Service Act subsection 224(q), codified at 42 U.S.C. § 233(q) This acknowledgment of notification of the limitation on liability is being provided before health care services have been provided to me by this individual. _____(initials)

Patient Consent for E-prescribing and Web Portal Invite: I agree that CCHC may e-prescribe my prescriptions and may request and use my prescription medication history from their healthcare providers or third-party pharmacy benefit payers for treatment purposes. Additionally, if I provided an email address, I understand CCHC will send me an invitation to join the web portal and I have received a copy of the Patient Portal User Agreement. _____(initials)

No Show Policy: A "no-show" refers to a patient who misses an appointment without cancelling/re-scheduling with at least 24-hour notice by phone, portal, text, or in-person. To accommodate the significant number of individuals waiting for appointments, I acknowledge that if I "no show" to three (3) appointments in a 12-month period, I may not be allowed to make scheduled appointments and may have to come in on a walk-in only basis for a six-month period. _____(initials)

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Taking of pictures and/or recording of video/audio: I consent to clinic photo, audio, or video recording by CCHC and its medical, nursing and other professional staff members. I understand that the purposes of these photos are for identification, documentation processes of diagnosis and/or treatment. I acknowledge that these photo/audio/video recordings are used for the provision of care, quality improvement, education, and/or reimbursement purposes. _____(initials)

Authorization for Release of Medical Information: Some patients prefer that certain individuals, including family members, be allowed access to their medical information. The individuals I opt to identify below have my permission to make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of my diagnosis, prognosis, and treatment plans, billing information, and serve as an emergency contact. I can let CCHC know at any point if I want to change or limit this permission. This permission applies to telephone and answering machine messages as well as other means of communication. For more detailed information about how health information is shared with others, please see the CCHC Notice of Privacy Practices. _____(initials)

Please Indicate name and relationship of person(s) you would like to grant access to below. (Additional names can be added to the back of this form if necessary.)

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

These consents will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not influence any actions taken prior to receiving the revocation.

Patient Signature: _____ Date:_____

Legal Guardian (if applicable) Print Name:_____ Signature: _____

Telephone: _____ Relationship: _____ Date:_____

PATIENT RIGHTS AND RESPONSIBILITIES

As one of our clients, you have choices, rights, and responsibilities:

YOU HAVE THE RIGHT TO…

Be treated with dignity and respect. Maintain your privacy and confidentiality.
Receive explanations about any tests or clinic procedures and any questions you may have. Receive education and counseling.
Review your medical record with a doctor or practitioner.
Consent to or refuse any care or treatment.
Participate in making plans or decisions about your care.

YOU ALSO HAVE THE RESPONSIBILITY TO…

To be honest about your medical history and lifestyle which may affect your health. Be sure you understand.
Follow health advice and instructions. Respect Health Center policies.
Report any changes in your health.
Keep appointments or cancel them at least 24 hours in advance.