SONOMA·VALLEY COMMUNITY HEALTH CENTER

Patient Identifying Label

Last Name	First Name		Middle Name
Social Security Number	Date of birth (mm/dd/yyyy)	Gender at birth: □ Male □ Female	Current Gender: □ Male □ Female
Street address: (Physical Address)		Is it OK to send mail to your address? □ Yes □ No	
City State Zip		What is your marital status? (check one) □ Divorced □ Married □ Single □ Domestic partner □ Separated □ Widowed □ Life Partner	
Mailing Address:			
City State Zip			
Please select one of the following from the ethnicity listing: □ Mexican, Mexican American, Chicano/o □ Puerto Rican □ Cuban □ Another Hispanic, Latino/a or Spanish origin □ Not Hispanic		Do you need transportation to your Medical, Dental or Behavioral Health Visits here at the clinic? □ Yes □ No	
Please check one of the following from the race listing: □ Asian Indian □ Chinese □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian □ Native Hawaiian □ Other Pacific Islander □ Guamanian or Chamorro □ Samoan □ Black/African American □ White □ American Indian □Alaskan Native □ More than One Race		Preferred Language with Provider?	Do you need an Interpreter? □ Yes □ No
Home Phone Number:	Day-time Phone Number:	Email Address:	
Cell Phone Number:	Assigned Medical Provider:	SVCHC Patient Portal Access? □ Yes □ No	
Student Status: (check one) □ Student full time □ Student part time □ Not a Student □ Minor		Occupation:	Employer Name:
Are you a veteran of US Armed Forces? □ Yes □ No		□ Full time employed □ Part-time employed □ Retired	
Do you have a physical or mental disability that has prevented or will prevent you from working for more than a year? □ Yes □ No			

EMERGENCY CONTACT INFORMATION

Emergency contact: Spouse, Friend, Legal Guardian or Parent (if patient is a minor)	Relationship to patient	Phone number

GUARANTOR INFORMATION

Last Name First Name		Middle Name
Street address	Date of birth (mm/dd/yyyy)	Gender: □ Male □ Female
City State Zip	Phone Number	Relationship to patient

INSURANCE

Insurance company:	Start date:	
Employer:	ID #	Group #
Policy holder:	Policy holder's date of birth	Policy holder's social security #

HEALTH CENTER FUNDING INFORMATION

How many people in your family? (Yourself, spouse and minor children under 18 years)	What is your household annual income? (Income of the persons listed in your family if they are working)

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How did you hear about our clinic? (Please check all that apply)
□ SVCHC Employee □ SVCHC Website □ Billboard/Bus Ad □ Brochure/Flyer □ Building Sign □ Business/Agency □ Friend/Family
□ Fair/Festival/Event □ Hospital/Provider □ Internet □ Newspaper/Magazine □ Outreach □ School □ Patient □ TV/Radio

Protection of Health Information under the OCHIN Organized Health Care Arrangement

Sonoma Valley Community Health Center *is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org as a business associate of* ***Sonoma Valley Community Health Center*** *OCHIN supplies information technology and related services to* ***Sonoma Valley Community Health Center*** *and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems.*

OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by ***Sonoma Valley Community Health Center*** *with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.*

The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

PROTECTED HEALTH INFORMATION DESIGNEE:
I understand that the individuals identified below will be treated by Sonoma Valley Community Health Center as individuals involved directly in my care or my child's care, and as such, SVCHC will be allowed to release the patient's personal health information to these individuals for the purpose of treatment including making appointments and all other functions normally associated with individual patient care, payment, and health care operations.

Name of Designee: _____ Designee Date of Birth: _____

Designee Phone Number: _____ Relationship to Patient: _____

Name of Designee: _____ Designee Date of Birth: _____

Designee Phone Number: _____ Relationship of Patient: _____

Name of Designee: _____ Designee Date of Birth: _____

Designee Phone Number: _____ Relationship of Patient: _____

□ *I decline to provide a protected health information designee contact for myself or my child at this time.*

Patient Signature/Parent/Legal Guardian_____ Date: _____

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Dear Patient,

In order to continue the variety of services that we offer here at SVCHC and to continue to receive grant funding, we are required to collect the following information on every person that visits our facility. This information is reported as a cumulative number and not reported on individual patients.

Please take a few minutes to complete the following information request:

1. Have you or any family member done agriculturally related work in the last 3 years?
   - ☐ Yes
   - ☐ No

2. If yes, was it migrant farm work in which you travel from town to town without establishing a permanent residence?
   - ☐ Yes
   - ☐ No

3. If yes, was it seasonal farm work in which you travel and work seasonally and have an established residence in the same area?
   - ☐ Yes
   - ☐ No

4. Are you Homeless?
   - ☐ Yes
   - ☐ No

5. If yes, where did you stay/sleep last night?
   - ☐ Doubling Up
   - ☐ Shelter
   - ☐ Street (includes car or other vehicle)
   - ☐ Transitional (includes hotel/motel)
   - ☐ Unknown

6. For reminder calls, which is your preferred method of contact?
   - ☐ Email
   - ☐ Phone Call (If checked, please circle one of the following: home number or cell phone.)
   - ☐ Text
   - ☐ None

7. You have the right to request to be contacted at a different location or by a different method.

SVCHC will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, please provide the contact information below:

_____

Street Address City State Zip Code

Alternative Telephone: _____

Thank you for providing this information to SVCHC. This will ensure that we are able to provide you with valuable services and programs in the future.

SVCHC FO Staff Initials: _____

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CONSENT TO TREATMENT:

I hereby request and consent to diagnostic procedures, tests, and medical treatment, family planning, birth control methods, and immunizations as deemed advisable by the professional staff of Sonoma Valley Community Health Center (SVCHC). I am aware that a Physician or a Nurse Practitioner may provide the medical care to my family or me. Services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at any of the Sonoma Valley Community Health Center clinic sites. I may cancel this consent in writing. *I consent to allow my assigned Primary Care Provider at Sonoma Valley Community Health Center to have access to all services provided to me at the health center including behavioral health services.*

Signed: **X**_____ _____

Patient Signature / Parent or Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (Print) Relationship

AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS:

I authorize SVCHC to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also SVCHC may use and release any part of my medical records necessary to the process of billing third party payers for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Sonoma Valley Community Health Center for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any Sonoma Valley Community Health Center account may be applied to my patient balance. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: **X**_____ _____

Patient Signature / Parent or Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (Print) Relationship

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SLIDING FEE DISCOUNT PROGRAM

ACKNOWLEDGEMENT

Sonoma Valley Community Health Center (SVCHC) offers a Sliding Fee Discount Program for those persons whose income is at or below 200% of the poverty. You must fill out a “Sliding Scale” application and provide verification of your income. This will allow SVCHC to accurately determine the fee you and your family will pay for each medical, dental, optometry and behavioral health visit. You and your family may qualify for the Sliding Fee Discount Program even if you have insurance.

I have received information on the Sliding Fee Discount Program. I accept and understand the conditions of the Sliding Fee Discount Program and:

- □ I wish to participate in the Sliding Fee Discount Program
- □ I do not wish to participate in the Sliding Fee Discount Program
- □ I do not qualify for the Sliding Fee Discount Program

Signed: **X**_____ _____

Patient Signature / Parent or Legal Guardian Signature (Please circle one) Date