CommuniCare HEALTH CENTERS

Patient Registration

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth

Mailing Address	City	State	Zip Code
Street Address	City	CA	Zip Code

Home Phone Number: ________________________________ Cell Phone Number: _____________________________
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 ☐ Lesbian or Gay ☐Queer ☐ Bisexual ☐ Don't Know ☐ Decline to Answer
☐ Additional category (Please specify)____________

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

Marital Status (Check one): ☐ Divorced ☐ Married ☐ Partnered ☐ Single ☐ Widowed ☐ Legally Separated	Social Security Number:

Emergency Contact (if none must state none):

Last Name	First Name	Relationship to patient	Phone Number

Insurance Type (Check one):
☐ MediCal/Partnership ☐ Private Insurance ☐ Covered California ☐ Medicare ☐ None ☐ Other (Please specify)________

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	Where are you currently living? (Check all that apply): ☐ Home/Apartment ☐ Shelter ☐ Staying with friends/family ☐ Outside (Street/Car) ☐ Transitional Housing ☐ Other (Please specify)____________
Are you a Veteran? ☐ Yes ☐ No	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

CommuniCare HEALTH CENTERS

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)**

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. _______ **(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)**

Late Policy: I acknowledge that if I am more than five (5) minutes late for my appointment, I may need to wait in order to be seen at the next available opening. Please note: While every effort will be made to see you, we cannot guarantee an appointment will be available. You are more than welcome to reschedule your appointment, if you are unable to wait. _______ **(initials)**

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 other individuals, especially family members, be allowed access to their medical information. To comply with strict legal standards, a written release is required to allow another person access to your medical records. This release grants permission to individual(s) to make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication.
_______ **(initials)**

Patient Signature: ______________________________________ **Date:** ________________
Legal Guardian Print Name: ____________________________________ **Signature**: _________________________
Telephone: (__ _)_______-___________ **Relationship:** _____________________ **Date:**________________

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 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.