Patient Registration Form

Would you like assistance filling out this form? □ Yes □ No | Do you need a translator for your visit? □ Yes □ No

Primary Spoken Language: Spanish English Other: ______________ | Do you need assistance with the following? □ Vision □ Mobility □ Hearing

Today's Date: ______________ **Date of Birth:** ______________ **Social Security #:** ______________

Preferred Name: ______________________ **Preferred Pronouns:** □ She □ He □ They □ Other: ________

Patient's Legal Name: ____
Last First MI

Mailing Address: ____
City State Zip Code

Physical Address: ____
City State Zip Code

Phone Numbers: ____
Home Cell Work Other

Best way to contact you: □ Voice □ Text □ Email | **Enroll in Patient Portal?** □ Yes □ No

Email: ______________________________ | **Are you financially responsible for your visits?** □ Yes □ No

If not responsible, complete the following: ____
Last First Relationship Phone#

Emergency Contact: ____
Last First Relationship Phone#

Mailing Address: ____
City State Zip Code

Primary Care Provider (PCP): □ John Rochat (MD) □ Cindy Novella (FNP) □ Cary Smeltzer (DO) □ Jess Dawdv (FNP)

Do you have Insurance Coverage?
□ Self Pay (30% discount if you pay on day of service) □ Yes (present Ins. Card to receptionist)
□ No, I would like to apply for one of the following: □ MediCal or Sliding Scale (income based)
□ Private Insurance through CoveredCA (only available during open enrollment)

Primary Ins.: □ MediCal/PHC □ Medicare/Other ID/Subscriber#: ______________ Plan/Group#: ________

Secondary Ins.: □ MediCal/PHC □ Medicare/Other ID/Subscriber#: ______________ Plan/Group#: ________

Dental Ins.: □ Medi-Cal □ Private ID/ Subscriber#: ______________ Plan/Group#: ________

Household Income (for grant purposes)**:**
Number of dependents including yourself: __________ Family's yearly Income before Taxes: $______________

Patients Sex at Birth:
□ Male
□ Female
□ Intersex

Sexual Identity:
□ Straight or Heterosexual
□ Lesbian, gay or homosexual
□ Bisexual
□ Something else: ______________
□ Don't know
□ Choose not to disclose

Gender Identity:
□ Female/Women
□ Male/Man
□ Transgender Male/Masculine
□ Transgender Female/Feminine
□ Genderqueer/Gender Nonconforming
□ Choose not to disclose

Race (Check all that apply)**:**
□ White
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Native Hawaiian
□ Pacific Islander
□ American Indian/Alaska Native
□ African American/Black
□ Guamanian/Chamorro
□ Samoan
□ Asian Indian
□ Other Asian: ______________
□ Choose not to disclose

Ethnicity (Check all that apply)**:**
□ Cuban
□ Puerto Rican
□ Mexican American
□ Another Hispanic, Latino or Spanish: ______________
□ Non-Hispanic or Latino/a or Spanish Origin
□ Choose not to disclose

*** Our mission is to provide excellent and affordable care to the community of Anderson Valley and beyond. ***
*** AVHC is an equal opportunity provider and employer. ***

The following questions are to help you and our community: Anderson Valley Health Center is a not-for-profit corporation. The grants we get help us give services to people who cannot afford to pay full cost. Answering these questions will help us serve you and the community.

Check all that apply to you:

- □ Veteran
- □ Seasonal agriculture worker:
  - Example: My main job is agriculture, and I don't work year-round.
- □ Migrant agricultural worker:
  - Example: My main job is agriculture; I don't work year-round, and I move to find more work.
- □ Living in transitional housing:
  - It is a temporary housing program with help to later transition into permanent housing
- □ Living in a homeless shelter
- □ Living on the street or in a car/tent
- □ Staying temporarily with friends/family
- □ Other housing situation, please describe: ______________________________

TREATMENT CONDITIONS

Consent to Treatment: By signing below, the patient authorizes Anderson Valley Health Center (AVHC) and its providers to perform any diagnostic procedures and treatments deemed necessary, based on the provider's professional judgment.

Medicare Assignment: The patient certifies that all information provided in connection with their application for benefits under Title VII of the Social Security Act is accurate. The patient authorizes any approved Medicare benefits to be paid directly to AVHC on their behalf.

Assignment of Insurance Benefits: If the patient is entitled to benefits under any insurance policy or from any party liable to them, they authorize those benefits to be assigned directly to AVHC for payment toward their account. The patient agrees that AVHC may issue a receipt for such payments, and that the insurance company will be released from further obligation under the policy to the extent of the payment. The patient remains responsible for any charges not covered by insurance or this agreement.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR MEDICAL CARE OPERATIONS

By signing this form, the patient gives consent for Anderson Valley Health Center (AVHC) to use and share their individually identifiable health information ("Protected Health Information") for the purposes of treatment, payment, and health care operations.

The patient confirms they have received AVHC's ***Notice of Privacy Practices for Protected Health Information*** (you may request a copy from any of our reception staff), which explains in detail how their health information may be used and disclosed. The patient has the right to review this notice before signing the consent.

AVHC may update its ***Notice of Privacy Practices for Protected Health Information*** at any time. If changes are made, patients may request a copy of the revised notice.

Patients may ask AVHC to place additional limits on how their health information is used or shared for treatment, payment, or health care operations. While AVHC is not required to agree to these requests, any restrictions that are accepted will be honored.

This consent may be revoked at any time by submitting a written request. The revocation will apply to future uses and disclosures, but not to actions already taken based on the original consent.

If the patient or their authorized representative chooses not to sign this consent, AVHC may decline to provide treatment, unless legally required to do so. If the patient later revokes their consent, AVHC may discontinue treatment, except where continued care is mandated by law.

ACKNOWLEDGMET AND SIGNATURE

I have read and understand the information provided above. I acknowledge that I may request a copy of this form for my records. I have also received and reviewed Anderson Valley Health Center's Notice of Privacy Practices for Protected Health Information. I confirm that I am the patient, or an authorized representative legally permitted to act on behalf of the patient, and I consent to the terms outlined in this document.

Print Patient's Full Name:

Patient Signature: Date:

If minor, parent/Guardian Signature: Date:

Print parent/Guardian Full Name:

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