HILL COUNTRY HEALTH & WELLNESS CENTER
PATIENT REGISTRATION

PATIENT INFORMATION (Please print clearly) Name must match what is on your insurance card or ID or we may not be able to bill.

LAST NAME:_____ **FIRST:**_____ **MI:**_____

ANY ALIASES (Such as Maiden Name or Prev. Married Name):_____

MAILING ADDRESS: _____ **CITY:**_____ **ST:**_____ **ZIP:**_____

HOME ADDRESS (if different): _____ **CITY:**_____ **ST:**_____ **ZIP:**_____

HOMELESS: ☐SHELTER ☐TRANSITIONAL HOUSING ☐DOUBLED UP ☐STREET ☐OTHER

PHONE HOME: _____ **WORK:** _____ **CELL:** _____

MESSAGE#: _____ **EMAIL ADDRESS:** _____

Preferred Method of Contact: (Please Circle 2) HOME PHONE WORK CELL MESSAGE PHONE EMAIL TEXT

BIRTHDATE: _____ **SEX:** F M **SSN#**_____ **MARITAL STATUS:** S M D W SEP

EMERGENCY CONTACT:_____ **PHONE:**_____ **RELATIONSHIP:**_____

PARENT or GUARDIAN (if patient is minor) OR SPOUSE INFORMATION

PARENT OR SPOUSE NAME: _____ **SSN#**_____

ADDRESS (if different than patient):_____ **CITY:**_____ **ZIP:**_____

PHONE (if different than patient): **HOME:** _____ **WORK:**_____

CELL: _____ **BIRTHDATE:** _____ **SEX:** F M **MARITAL STATUS:** S M D W SEP

PATIENT DEMOGRAPHICS: 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 Circle or Check the appropriate box.

LANGUAGE SPOKEN IN YOUR HOME: ☐ENGLISH ☐SPANISH OTHER_____

RACE (You May Select Up To 2): ☐WHITE ☐BLACK / AFRICAN AMERICAN ☐NATIVE HAWAIIAN / PACIFIC ISLANDER ☐ASIAN ☐AMERICAN INDIAN / ALASKAN NATIVE ☐CHINESE ☐FILIPINO ☐JAPANESE ☐KOREAN ☐MORE THAN TWO RACES ☐OTHER ☐ DECLINED

ETHNICITY: ☐HISPANIC/ LATINO ☐**NOT** HISPANIC/LATINO ☐DECLINED

ARE YOU AN AGRICULTURAL (FARM) WORKER?: ☐YES ☐NO **If YES, ARE YOU:** ☐SEASONAL **OR** ☐MIGRANT

ARE YOU A VETERAN?: ☐YES ☐NO

WHAT IS YOUR FAMILY SIZE: _____ **WHAT IS YOUR FAMILY'S MONTHLY INCOME:** _____

Do you have a medical doctor?

Name of doctor: _____ Location/Facility:_____

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

SIGNATURE: _____ **DATE:** _____

03/17/2015

Hill Country Community Clinic Patient Financial Agreement

- **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:** Hill Country accepts Medi-Cal and CMSP. 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 patients who are unable to afford care**

✖ _____

Please Sign Here Date

Insurance information and authorizations

Insurance Company Name: _____

ID #: _____ Group #: _____

Policy holder Name: _____

Relationship to Patient: Self Spouse Parent Other

Policy Holder Address: _____

Policy Holder Date of Birth _____

- 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.

Authorizing signature and date

Patient Name_____

Responsible Party_____

_____

Signature of Responsible Party **Date**

11/19/2015 Reviewed by:_____

DENTAL HISTORY

What is the reason for your visit today?

_____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning**_____ **Last Full Mouth X-Rays**_____

What was done at your last dental visit?_____

_____

Previous Dentist's Name? _____

Address _____ State_____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors of bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where?_____

Do you:		
Clench or grind your teeth while awake of asleep?	Yes	No
Bite your lips of cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake of asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore of have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products presently?	**Yes**	**No**

How many packs/cans per day_____

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause: _____

_____

Have you ever experienced:		
Clicking pr popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening of closing the mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern?	Yes	No

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe_____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, Please describe _____

_____

(Please complete other side)

Name_____ **DOB**_____ **Date** _____

MEDICAL HISTORY

1. Physicians Name_____ Phone ( )_____
   Have you had any medical care within the past two years?..... Yes No
   Describe_____
2. Have you taken any medication or drugs during the past two years?..... Yes No
3. Are you currently taking an medication, drugs, pills, or herbal remedies, including regular dosages of aspirin?..... Yes No
   If yes, please list name and dosage_____ Yes No
4. Have you ever taken prescription medications for weight loss (diet pills)?..... Yes No
   If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues?..... Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva of other similar drugs?..... Yes No
6. Are you aware of having an allergic (or adverse) reaction to any substance of medication?..... Yes No
   If yes, please specify_____
7. Have you been a patient in the hospital during the past five years?..... Yes No

Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers.....	Yes	No	Hepatitis A B C (circle)...	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Venereal Disease.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems.....	Yes	No	A.I.D.S. / H.I.V. Positive.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	Cold Sores / Fever Blisters.....	Yes	No
High / Low Blood Pressure.....	Yes	No	Contact Lenses.....	Yes	No	Blood Transfusion.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Hemophilia.....	Yes	No
Artificial Heart Valve / Pacemaker	Yes	No	Chronic Cough.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Tuberculosis.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis / Rheumatism.....	Yes	No	Asthma.....	Yes	No	Liver Disease / Yellow Jaundice.....	Yes	No
Cortisone Medicine.....	Yes	No	Hay Fever/Allergy/Hives..	Yes	No	Neurological Disorders.....	Yes	No
Swollen Ankles.....	Yes	No	Latex Sensitivity.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Fainting of Dizzy Spells.....	Yes	No
Diet (Special / Restricted).....	Yes	No	Radiation Therapy.....	Yes	No	Nervous / Anxious.....	Yes	No
Artificial Joints (hip, knee, etc.)...	Yes	No	Chemotherapy.....	Yes	No	Psychiatric / Psychological Care....	Yes	No
Kidney Trouble.....	Yes	No	Tumors.....	Yes	No			

Have you lost or gained more than 10 pounds in the past year?.....
Do you have or have you had any disease, condition, or problem not listed?.....
If yes, please list:_____

Women: Are you pregnant or think you could be pregnant Yes _____Months No Nursing? Yes No

Do you use birth control prescriptions?..... Yes No

I understand the above information is necessary to provide me with dental care in a sage and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient\Guardian Signature_____Date_____

History Review

Dentist Signature_____Date_____

HILL COUNTRY HEALTH AND WELLNESS CENTER

SHARED PATIENT INFORMATION
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. Following is a list of the information that will be shared:

- Your physical & mental health conditions and history, including diagnoses and prognoses;
- Specific concerns about your health, safety or emergency needs;
- Results of tests or other evaluations used to diagnose or develop interventions;
- Your treatment goals and plan, including prescribed medications and other recommendations;
- Your follow up plan, including referrals for other care types or specialties;
- Updates regarding your health status, functioning, participation, and progress.

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.

Please sign below:

I authorize Hill Country providers (medical, dental and behavioral health) to share information as stated above.

_____ _____
Signature Date

_____ _____
For Minors, Signature of Parent /Guardian (please state relationship) Date

Witness: _____

Revised 7/20/2014

HILL COUNTRY COMMUNITY CLINIC
CONSENT FOR MEDICAL/DENTAL TREATMENT

Patient Name: _____

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 and dental treatment to me.

SIGNED:_____ Date:_____

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 and dental treatment to said minor. This consent shall remain in force until a written revocation is filed at the clinic.

SIGNED:_____ Date:_____
(parent/guardian)REV. 9/92

Hill Country Community Clinic

About Our 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's Signature **Date**

Signature of Parent or Patient's Representative (if applicable) **Date**

Description of Legal Authority to Act on Behalf of Patient **Date**

Hill Country Health & Wellness Center
Photo Release Form

I hereby give Hill Country Health & Wellness Center consent to record, videotape and photograph my image and/or voice to be used in the following ways:

- Company intranet accessible by employees only
- Company internet accessible via the World Wide Web to anyone
- Printed employee newsletters
- Printed customer newsletter, marketing materials, ads
- Video, audio or photo ads, commercials, marketing
- Cavity Free Club

I understand that photographs and/or video taken of me will be kept confidential and only shared with the appropriate people. My personal information will be kept anonymous if my photograph and/or video are used in a presentation.

I further understand that no special compensation will be provided to me for use of my image and that I may not be informed in advance of the specific use of my image.

Name: _____ Date: _____

Signature: _____ Date: _____

Parent Guidelines

At Hill Country Health and Wellness Center we have your child's best interests at heart. The agreement below will help your child be healthy, safe, and happy at his or her next dental visit.

Can I be in the treatment room with my child?

You may choose whether or not you accompany your child to his/her dental appointment. Although we sense that *some children do better without parents present*, we are open to having you with your child. If you choose to be present, we suggest the following guidelines to improve chances of having a positive outcome.

1. Please be a *silent* observer.
   a. This allows us to maintain communication with your child.
   b. Children will normally listen to their parents instead of us and may not hear our guidance.
   c. You might have incorrect or misleading information.
2. If asked to leave the room, be ready to immediately walk away.
   a. Many children will try to control the situation.
   b. "Acting out" is normal, but unacceptable during dental procedures.
   c. This is intended to "short circuit" the control attempt.
   d. We will continue to support your child at all times.
3. Please use our terminology:

In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We avoid using words that scare children. Please support us by using positive words that are often used for dental care. These include:

Positive Words (use these words)	Negative Words (do not use these words)
Sleepy Juice	Needle or Shot
Whistle	Drill
Polish Tooth	Drill on Tooth
Wiggle	Pull or Yank Tooth
Sugar Bugs	Decay or Cavity
Tickle Teeth	Teeth Cleaning

Staff Initials: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Hill Country Community Clinic

29632 Highway 299 East, P.O. Box 228
Round Mountain, California 96084
Phone 530-337-6243 Fax 530-337-6655

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Please print clearly.

Patient's Name: _____ Phone #: _____

AKA: _____ Date of birth: _____

Address: _____

I understand that there may be a fee for processing this request. The address and phone number stated above are correct for billing purposes. I will be notified of fees and required to pay for processing before the records are released _____
(signature required here)

HCCC Clinician _____ Chart # _____

Description of and/or limitation on information to be disclosed:

_____ immunization records
_____ recent history and physical
_____ recent and current problem list
_____ recent and current medication list
_____ all medical records
_____ progress notes from _____ to _____ (dates)
_____ lab results from _____ to _____ (dates)
_____ x-ray/imaging/diagnostic reports from _____ to _____ (dates)
_____ other: _____

_____

Disclosure of information to be made **from:**
(name & complete mailing address of who is to release information)

_____

_____

Disclosure to be made **to:**
(name & complete mailing address of who is to receive information)

_____

_____

Purpose of disclosure/specific use of information: _____

_____

All Copying & Billing (under 10 pages are free) 10 pages or more will be done by: Professional Medical Copy Service 2700 Eureka Way, Redding, CA. 96001 (530) 241-2971 Charges for medical record copying as governed by Professional Medical Copy Service and California Health & Safety Code #123110 (pricing to be determined and subject to change by Professional Medical Copy, not Hill Country Health and Wellness Center)

Initial _____

(over →)

I understand that I have the right to cancel this authorization at any time. I understand that if I cancel this authorization, I must do so in writing and present my written cancellation to the Medical Records Department. I understand that it will not apply to information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect of have copied the information to be used or disclosed, as provided in CFR 164.524. I understand that the information disclosed may be redisclosed and the redisclosure may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Medical Records Department Manager at 337-6243 ext: 15.

Signature required in this section only if records include type of information listed below.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I authorize the release of this type of information:

_____ Sexually transmitted disease
_____ HIV/AIDS
_____ Psychiatric/Mental Health Services
_____ Alcohol or drug abuse treatment

_____

(signature – if records include above type of information)

I understand that I have a right to receive a copy of this Authorization form.

Signature always required in this section

Unless otherwise cancelled, the disclosure of medical information is no longer authorized on _____ **(specific expiration date or event)**, or in 6 months if no date or even stated.

_____ _____

[Signature of Patient or Legal Representative] [Printed name of person signing form]

_____

[If signed by Legal Representative: relationship to patient or description of authority to act]

_____ _____

[Signature of Witness, if applicable] **(Date signed)**

For Office Use Only:
Patient I.D:_____
D.O.B:_____
Effective Dates: _____To:_____
Scanned by :_____
Multiple Scans: (1X) (2X) (3X) (4X) (5X)

Hill Country Health and Wellness Center

Sliding Fee Scale discount program

Hill Country (HCCC) offers a "Fee Discount" program. Many individuals qualify for the Sliding Fee Scale Program and can receive low cost health services. To qualify, an individual must meet Federal family income criteria.

Requirements of the Sliding Fee Scale program:

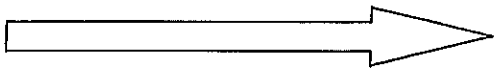
1. You must complete the Financial Information/Program Application form annually to determine your eligibility and discount. This information includes:
    a. Your total household income from all income sources before taxes
    b. Number of family members living in your household
2. At our discretion, we may require proof of information stated on the Sliding Fee Scale Program application.
3. Your discount may vary if your income changes.
4. Your fee is due at each visit.
5. Sliding Fee Scale payments are refundable whenever HCCC receives payment from the insurance for that date of service.
6. Services offered under the HCCC Sliding Fee Scale program are limited to those deemed medically necessary by appropriate Clinic staff. Cosmetic and elective health services do not qualify for the program.

Important Note: Some services may include additional charges and may not be subject to the discount.

Medical Service Discounts and Exclusions

1. **LAB SERVICES:** If your health care provider orders lab work, (blood or urine test, etc.), you will get a discount if they are basic lab tests performed at HCCC or at any LabCorp facility. There is a fee for all lab charges, payable at the time of the visit. It will be your responsibility to pay 100% of the charge if any other lab is used or for any lab work that must be sent away for testing. The laboratory staff can tell you what the tests will cost.
2. **X-RAY SERVICES:** If your health care provider orders x-rays, you will get a discount if they are performed at Medical Doctors Imaging (MDI) or on site at Hill Country and are paid for at the time of service.
3. **SPECIAL STUDIES:** Your health care provider may order special diagnostic studies (such as a sonogram or CT). You will be responsible for 100% of these charges and must make arrangements to pay the facilities that provide them.

Please let us know if you have any questions about our programs or services. We are here to assist you.

Please complete and sign the back side of this form 

07/1/2015

Hill Country Health & Wellness Center Sliding Fee Program Application for Health Services Discount

Hill Country Clinic offers many discounts for health services. You must complete this form to apply for these discounts. All information will be kept strictly confidential. Payment is due at time of service.

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

Responsible Party:_____ **Date of Birth:**_____ **ACCT#:**_____

Address:_____ **Home Phone:**_____

City:_____ **State:**_____ **Zip:**_____ **Cell:**_____

PT ID	House Hold Family Members (include self)	Relationship	Date of Birth	Age	Gross Monthly Income	Name of Current Insurance Plan

List any additional family members on the additional page if needed.

Definition of House Hold Members for Hill Country: All family members (Self, spouse, domestic partner and children) living in your household and supported by the family income. This would also include any children under the age of 21 who are away at school who are being claimed as tax dependents. To qualify additional household members (such as an older parent), you must be claiming them on your tax return. People residing with you temporarily, while looking for housing, or during transitions in their lives, should apply for the sliding scale on their own as individuals.

Definition of Gross Monthly Income for Hill Country: List the source of any earned or unearned income and the amount (before taxes or deductions). This is to include income from employment, tips, commissions, pensions, social security, child and/or spousal support, ongoing insurance payments, disability, Veterans Affairs, unemployment benefits, etc. For self-employment you would include all net profit. When listing a House Hold Member who has any of the above Incomes then you must list their income.

You must inform HCCC if your income changes during the time you are receiving these discounts. I state that the information I provided above is true and accurate to the best of my knowledge. I understand that deliberately providing false information may void this application and any related discounts.

Applicant's Signature:_____ **Date:**_____

OFFICE USE ONLY: **OVER INCOME/DENIED:** ☐ **PT REFUSED APPLICATION:** ☐ **CATEGORY:** A B C D E

TOTAL HOUSEHOLD INCOME:_____ **FAMILY SIZE:**_____ **SF% DISCOUNT**_____

REVIEWED BY(Initial):_____ **DATE REVIEWED:**_____ **EFFECTIVE DATE:**_____ **RENEW DATE:**_____