Chart #______________

PATIENT REGISTRATION

Patient Information **(Please print clearly)** Name must match what is on your insurance card(s) or we may not be able to bill.

Last Name: ______________________ **First:** ______________________ **M:** ________

Birthdate: ____________ **Sex:** ❑F ❑M **SSN#** ______________ **Marital Status:** ❑S ❑M ❑D ❑W ❑SEP

Mailing Address: ______________________ City: ______________ ST: _____ Zip: ________

Physical Address (if different): ______________________ City: ______________ ST: _____ Zip: ________

Home Phone: ______________ **Work:** ______________ **Cell:** ______________

Message#: ______________ **Email Address:** ______________________

Preferred Method of Contact: ❑Home Phone ❑Work ❑Cell ❑Message Phone ❑Text **Okay to Leave Message?:** ❑Yes ❑No

Emergency Contact: ______________________ **Phone:** ______________

Relationship: ______________ **Does this person know that you are a patient at Hill Country?** ❑Yes ❑No

---

Parent or Guardian **(if patient is minor)**

Parent/Guardian Name: ______________________ Date of Birth: ______________

Address: ______________________ Relationship to Minor: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Parent/Guardian Name: ______________________ Date of Birth: ______________

Address: ______________________ Relationship to Minor: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

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 (Check all that apply): ❑White ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑Asian ❑Chinese ❑American Indian/Alaskan Native ❑Filipino ❑Japanese ❑Korean ❑Other ❑Declined

Ethnicity: ❑Hispanic/Latino ❑Non-Hispanic/Latino ❑Declined

Sexual Orientation: ❑ Lesbian, Gay or Homosexual ❑Straight or Heterosexual ❑Bisexual ❑Don't Know ❑Choose not to disclose ❑Other______________

Gender Identity: ❑ Male ❑Female ❑Transgender Male/ Female-to-Male ❑Transgender Female/ Male-to-Female ❑ Genderqueer Neither Exclusively Male Nor Female ❑ Choose Not To Disclose ❑Other: ______________

Are you a Veteran?: ❑Yes ❑No **Agricultural (Farm) Worker?:** ❑Yes ❑No **If yes, are you:** ❑Seasonal ❑Migrant

Homeless: ❑Yes ❑No **If yes, currently living in:** ❑Shelter ❑Transitional Housing ❑Doubled Up ❑Street ❑Other

Family Size: ________ **What is your Average Monthly Income:** ____________ **❑Declined to provide information**

SIGNATURE: ______________________________ **DATE:** ______________

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

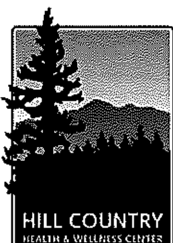

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Chart #______________

PATIENT CONSENTS

Consent for Medical/Dental Treatment

Patient Name:____ **Date of Birth:** ____________

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.

If 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.

Patient Signature:____ Date:__________________

Parent/Guardian Signature:______________________________________ Date:__________________

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 Signature:____ Date:__________________

Parent/Guardian Signature:______________________________________ Date:__________________

Confidential Health History

Chart #__________

Patient Name: ____________________ Date of Birth: __________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: __________
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: __________
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: __________
4. Yes / No Are you being treated by a physician now? If YES, explain: __________
   Date of last medical exam? __________ Reason for exam: __________
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: __________
   Date of last dental exam: __________ Name of last treating dentist: __________
6. Yes / No Are you in pain now?
   If YES, explain: __________

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

Other: __________

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

Other: __________

Chart # ____________

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium or other sedatives	Yes / No Codeine or other narcotics
Yes / No Penicillin or other antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No Local anesthetic	Yes / No Metal

Others: ____________________

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Anti-Depressants	Yes / No Herbal Supplements	

Please list all prescription medications: ____________________

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? ____________________

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: ____________________

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: ____________________

Yes / No Have you ever taken Fen-Phen? If YES, when: ____________________

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: ____________________ Date: ____________

Physician's Name: ____________________ Phone Number: ____________

Whom would you like us to contact in case of an emergency?

Name: ____________ **Relationship:** ____________ **Phone Number:** ____________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____________________ ____________ ____________________ ____________

Signature of Patient (Parent or Guardian) | Date | Signature of Dentist | Date

Chart #____________

PATIENT FINANCIAL AGREEMENT

Medical & Dental Insurance Policies

Primary MEDICAL Insurance

Name: ____

Policy ID#________________ Group #________________ Effective Date: ________

Guarantor Name:________________________ Relationship to patient:________

Date of Birth:____________ SSN#:________________ Sex: ☐F ☐M

Address: ________________________________ Phone:____________

Secondary MEDICAL Insurance

Name: ____

Policy ID#________________ Group #________________ Effective Date: ________

Guarantor Name:________________________ Relationship to patient:________

Date of Birth:____________ SSN#:________________ Sex: ☐F ☐M

Address: ________________________________ Phone:____________

DENTAL Insurance

Name: ____

Policy ID#________________ Group #________________ Effective Date: ________

Guarantor Name:________________________ Relationship to patient:________

Date of Birth:____________ SSN#:________________ Sex: ☐F ☐M

Address: ________________________________ Phone:____________

PLEASE PROVIDE YOUR PRESCRIPTION COVERAGE CARD IF DIFFERENT FROM THE INFORMATION PROVIDED ABOVE

Chart #____________

Medicare Beneficiary Screening

Please answer the following questions ONLY if you have Medicare Insurance

As a direct result of mandated Medicare Secondary Payer (MSP) Regulations, HCCC is required to gather information to determine if Medicare is your primary insurance.

1. Is this visit due to an automobile accident, liability accident or Workman's Compensation? ☐Yes ☐No
2. Is this visit covered by the Black Lung Program, Veterans Administration program or a Government Research Program? ☐Yes ☐No
3. Under 65 and an end stage renal patient in your first 36 months of Medicare entitlement? ☐Yes ☐No
4. If under age 65, is your Medicare coverage due to disability? ☐Yes ☐No
5. Are you covered by a health plan through your employer or spouse's employer? ☐Yes ☐No

=

Office use only:
A. If patient responds "no" to questions 1-5, Medicare is primary.
B. If patient responds "yes" to any questions 1-5 and there is a second insurance (other than "Medicare Supplemental plan, Part D or Medi-Cal), Medicare is secondary and primary insurance information must be obtained.

Payment and Billing Policy

- **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 qualifying patients who are unable to afford care

- 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.

I have read the above Patient Financial Agreement and agree by signing below.

Patient Signature:______________________________ Date:______________

Parent/Guardian Signature:______________________________ Da ______________

Chart #______________

ADDITIONAL CONSENTS OR DISCLOSURES

Patient Consent for the Release of Information on Voicemail or Answering Machine

I, ____________________________ , give my permission for the following normal information (Lab results, Pap test results, Pathology reports, X-ray results) and Referrals, Prescriptions, and Appointment information to be left on the voicemail/answering machine of my choice.

I understand I also have the option to review or request some of this information via the Patient Portal.

Please select all that apply:

- ☐ Home Phone: ____________________
- ☐ Work Phone: ____________________
- ☐ Cell Phone: ____________________
- ☐ Other: ____________________

This authorization is effective until rescinded by myself in writing.

Patient Signature:______________________________ Date:______________

Parent/Guardian Signature:______________________________ Date:______________

Parental Delegation of Authority to Seek Health Care Services for Minor Dependent

I, ______________________________ (Parent or Legal Guardian) ______________________ (Relationship to Minor) of

______________________________ (Minor) ______________________ (Date of Birth) give authorization

for ______________________________ (Print Name) ______________________ (Relationship to Parent/Guardian) to bring

minor to **Hill Country Community Clinic** for medical and/or dental treatment in the event that I am unavailable to do so. **This authorization is effective until rescinded by myself in writing.**

Patient Signature:______________________________ Date:______________

Parent/Guardian Signature:______________________________ Date:______________

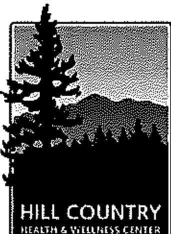

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Chart #______________

Patient Consent to Obtain Medication History

As a user of an electronic medical record, your Hill Country provider would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

An accurate medication history is **very important** to help us treat you and to avoid potentially dangerous drug interactions.

Your medication history might not include over the counter medicines, supplements or herbal remedies. **It is still very important for us to take the time to discuss everything you are taking,** and for you to tell us about any errors in your medication history.

Please initial your choice and sign below.

________ **I give permission** for Hill Country Health and Wellness Center to obtain my medication history from my pharmacy, my health insurance (including state and federal benefits programs) and any other healthcare providers or drug and alcohol treatment programs. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

OR

________**I DO NOT give permission for** Hill Country Health and Wellness Center to obtain my medication history from my pharmacy, my health insurance nor my other healthcare providers.

By signing this consent form without making a selection, you are consenting to giving permission to Hill Country Community Clinic to obtain medication history from locations stated above.

Patient Signature:____ Date:________________

Parent/Guardian Signature:________________________________ Date:________________

Conflict of Interest Disclosure

If there is anyone employed at Hill Country Community Clinic that you do not want to have access to your medical, dental, or behavioral health records, please list their names and the reason why:

1. ____
   ____
2. ____
   ____

A representative from our office may contact you for more information. All information disclosed is kept confidential and used only to keep your personal information secure.

Chart #____________

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 only if they are performed at Medical Doctors Imaging (MDI).
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.

If you choose to NOT apply for this program, please check the box below, sign and date.

☐ **I choose not to participate in this program. I understand that I will not receive any additional discounts for services that are not covered by my health plan.**

Signature:______________________________ **Date:**____________

Please complete and sign the other side of this form if you want to participate in the Sliding Scale Program

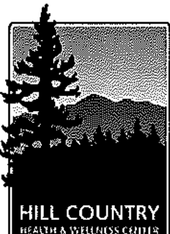

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Chart #______________

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

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 <u>any</u> of the above Incomes then you <u>must</u> 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:** ________ **SCANNED:** ______X's

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

Chart #______________

HILL COUNTRY HEALTH AND WELLNESS CENTER SHARED HEALTH INFORMATION PROTECTION POLICY & 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.**

Hill Country also shares your health information using the regional Health Information Exchange, SacValley Med Share. This important feature allows your doctors at other locations (such as hospitals and emergency rooms) to quickly access to your health records even when our offices are closed. Hill Country and SacValley MedShare use the highest standards to ensure the safety and privacy of your records in this process. For more information about SacValley MedShare see their website at **http://sacvalleyms.org/**

The items that may be shared with your Hill Country healthcare teams and SacValley MedShare are identified in the follow table:

Hill Country Providers Only	**SacValley MedShare (HIE)**
• Physical and Mental health conditions, history, including symptoms and diagnoses, prognoses	• Allergies, Adverse Reactions
• Treatment goals and plan, including medications and other recommendations	• Problems list
• Results of test or other evaluations used to diagnose or develop interventions	• Medications list
• Specific concerns about your health, safety or emergency needs	• Vitals Signs
• Follow up plan, including referrals for other care types or specialties	• Encounter codes and procedure codes
• Updates regarding your health status, functioning, participation and progress	• Lab Results

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 **not** 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 read the following options carefully and check one box:

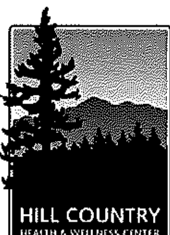
☐ **I authorize Hill Country Health and Wellness Center to share my health information with my providers at Hill Country AND SacValley MedShare as stated above.**

OR

☐ **I authorize Hill Country Health and Wellness Center to share my health information ONLY with my providers at Hill Country. I DO NOT allow my records to be shared using SacValley MedShare.** **Opt-Out form provided**______________________________

______________________________ ______________
Signature Witness (if required) Date

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



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