Family Health Matters
COMMUNITY HEALTH CENTER

New Patient Application

Your information is confidential. We will not share unless we have written authorization to do so.

PATIENT INFORMATION

Last Name: First Name: Middle:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Date of Birth (m/d/yyyy): Age:

Sex: ☐ Male ☐ Female

Preferred Language: ☐ English ☐ Spanish ☐ Tagalog ☐ Other: _____

Email: ☐ Prefer to not disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Choose not to disclose ☐ Other

Sexual Orientation: ☐ Straight ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Don't Know ☐ Something Else ☐ Choose not to disclose

Street Address:

Social Security Number:

Phone Number: ☐ Cell ☐ Home ( ) -

P.O Box:

City:

State:

Zip Code:

Homeless ☐ Yes ☐ No

☐ Doubling up ☐ Shelter ☐ Permanent Supportive Housing ☐ Transitional Housing ☐ Street ☐ Not Applicable ☐ Other: _____

Veteran ☐ Yes ☐ No Farm Worker ☐ Yes ☐ No Farm Worker Year Round ☐ Yes ☐ No
Limited English Proficiency ☐ Yes No Public Housing ☐ Yes ☐ No Disability ☐ Yes ☐ No

Income Range

Please choose which category you fall under based on your family annual income and size
Mark the box next to your family income and size.

Family Size	A	B	C	D	E
1	☐$12,880	☐$12,881 - $16,100	☐$16,101 - $19,320	☐$19,321 - $25,760	☐$25,761+
2	☐$17,420	☐$17,421 - $21,775	☐$21,776 - $26,130	☐$26,131 - $34,840	☐$34,841+
3	☐$21,960	☐$21,961 - $27,450	☐$27,451 - $32,940	☐$32,941 -$43,920	☐$43,921+
4	☐$26,500	☐$26,501 - $33,125	☐$33,126 - $39,750	☐$39,751 - $53,000	☐$53,001+
5	☐$31,040	☐$31,041 - $38,800	☐$38,801 - $46,560	☐$46,561 - $62,080	☐$62,081+
6	☐$35,580	☐$35,581 - $44,475	☐$44,476 - $53,370	☐$53,371 - $71,160	☐$71,161+

Ethnicity: ☐ Hispanic/Latino ☐ Decline to specify ☐ Non-Hispanic/Latino

Race: ☐ White ☐ African American ☐ Asian ☐ NA ☐ Pacific Islander ☐ American Indian ☐ Native Hawaiian

Referred to clinic by :
(Please check one box): ☐ Dr._____ ☐ Insurance Plan ☐ Hospital ☐ Family
☐ Friend ☐ Close to home/work ☐ Other: _____

INSURANCE INFORMATION

Please check all that apply:

☐ I have insurance ☐ I do not have insurance ☐ I need help getting insurance
☐ I would like to apply for a program to reduce the cost of the consult

Person responsible for bill:	Address (if different):	Phone number: ( ) -

Is this person a patient here? ☐ Yes ☐ No
Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Please indicate you primary insurance: ☐ Medical ☐ Medicare ☐ HMO ☐ PPO ☐ Private

Subscriber's name:	Subscriber's S.S No.:	Birth Date: / /	Group no.:	Co-Payment: $

EMERGENCY CONTACT	
Name of local friend or relative:	Relationship to patient:
Cell phone number:	Home phone number:

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorized my insurance benefits be paid directly to Family Health Matters. I understand that I am financially responsible for any balance. I also authorize Family Health Matters or insurance company to release any information require to process my claims.

_____ _____

Patient/Guardian Signature **Date**

_____

Parent/Guardian Name

Consent to Treatment

CONSENT TO TREATMENT: The undersigned hereby consent to the administration and performance of all diagnostic procedures and treatments, which, in the judgment of North Orange Regional Health Foundation (Family Health Matters Community Health Center), may be considered necessary or advisable.

I further agree that if I decide to leave the office without the written consent of the physician/provider, I shall be totally liable for the consequences of such decision.

CONSENT TO REVIEW MEDICATION HISTORY FROM THIRD PARTY SOURCES: The undersigned hereby provide Family Health Matters (FHM) consent to obtain and review your medication history.

A prescription history is a list of medications that we or other healthcare providers have prescribed for you. This list is collected from different sources, including your pharmacy and your health insurance.

A detailed prescription history will improve the accuracy of our prescription list in your medical record and will be used for treatment purposes.

I have read and understood the consent to obtain prescription history. This consent is valid for one year from the date signed, unless written request is given by patient to cancel.

- ☐ **NO** - I decline consent to obtain, view and use my prescription history.

CONSENT TO IMMUNIZATION RECORDS: I consent for my child's immunization/ TB test record to be shared with other health care providers, agencies, or schools using CAIR2

- ☐ **NO** – I decline to allow my child's immunization/ tuberculosis (TB) test record to be shared with other health care providers, agencies, or schools using the California Immunization Registry (CAIR2).

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION:

1. **PURPOSE.** The purpose of this form is to obtain your consent for a telemedicine consultation with a physician.
2. **NATURE OF TELEMEDICINE CONSULTATION.** Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo

recordings may be taken.

3. **RISKS, BENEFITS AND ALTERNATIVES.** The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local health care community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.

4. **MEDICAL INFORMATION AND RECORDS.** All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.

5. **CONFIDENTIALITY.** All existing confidentiality protections under federal and California law apply to information used or disclosed during your telemedicine consultation.

6. **RIGHTS.** You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. If you are a Medi-Cal recipient and receiving teleophthalmology or teledermatology by store and forward, you have the right to an interactive communication with the physician. This communication may occur at the time of your consultation or within 30 days after you receive the results of the consultation.

My health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to a telemedicine consultation

☐ **NO -** I decline to participate in a telemedicine consultation as described above.

_____ _____

Patient/Guardian Signature **Date**

_____

Patient/Guardian Name

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this form, I acknowledge receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides information about how we use and disclose your protected health information. We encourage you to read it in full.

Notice of Privacy is subject to change. If we change the notice you may obtain a copy of the revise notice by contacting our HIPAA Officer.

If you have any question about the Notice of Privacy Practices please contact Daisy Duarte at (714) 441-0411.

_____ _____

Patient Signature **Date**

Office Staff Only

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgment was not obtained.

Comment:

_____
_____
_____

_____ _____

Staff Signature **Date**

Release of Medical Information

Patient Name: _____ Date of birth: _____

I authorize the release of information including diagnosis, records, examination rendered to me & claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____
- ☐ Information may not be release to anyone.

This Release of Medical Information will remain in effect until terminated by me in writing.

Preferred Method of Contact

Please contact me at ( ) _____-_____ by ☐ phone call ☐ text message ☐ phone call and text

If unable to reach me:

- ☐ You may leave a detailed message.
- ☐ Leave a message asking me to return your call.
- ☐ Other: _____

The best time to reach me is: _____am _____ pm

_____ _____

Patient Signature **Date**

Advance Directives Acknowledgement

Patient Name: _____ Date of Birth: _____

☐ I ***do have*** an advance direct/living will/durable power of attorney for medical or health decisions.

☐ I ***do not have*** an advance directive/living will/durable power of attorney for medical or health decisions.

☐ I would like further information on advance directives

☐ I would not like further information on advance directives

Office Staff Only

☐ Information regarding advance directives was provided.

☐ Information regarding advance directives was not provided.

If information was provided, what type? ☐ verbal ☐ written

If the member has an Advance Directive, has it been placed in the Medical Record?

☐ Yes ☐ No

Comments:

_____

_____

_____ _____

Staff Signature **Date**