COMMUNITY Medical Centers

Patient Registration

PLACE LABEL HERE

PATIENT INFORMATION

Patient Name: _____ _____ _____
(Must match name on MediCal &/or ID) card) Last Name Middle Name First Name

☐ **Previous** ☐ **Preferred Name:** _____ **Date of Birth:** _____/_____/_____
Month Day Year

Birth Sex: ☐ Male ☐ Female **Preferred Pronoun:** ☐ She, Her, Hers ☐ He, Him, His ☐ They, Them, Theirs ☐ Ze, Hir ☐ Other ☐ Unknown ☐ Decline to State

Home Address: _____ **Apt.** ____ **City** _____ **State** _____ **Zip** _____

Mailing Address: _____ **Apt.** ____ **City** _____ **State** _____ **Zip** _____

Home Phone: _____ **Cell:** _____ **Work Phone:** _____

Best Phone Number for Contact: ☐ Home ☐ Cell ☐ Work ☐ Do not Call

Would you like to receive Voice Messages/Voicemails? ☐ Yes ☐ No, Do Not Leave Voice Messages

Would you like to receive Text Messages? ☐ Yes ☐ No, Do Not Leave Text Messages

Email Address: _____

When you share your demographic information with us it is kept confidential. It will help us provide you with the best care possible and allows us to maintain funding to provide essential health care services.

1. Race/Ethnicity
(Check ALL that apply)

- ☐ African American/Black
- ☐ American Indian/Alaskan Native
- ☐ Asian Chinese
- ☐ Asian Indian
- ☐ Southeast Asian
- ☐ Other Asian
- ☐ Hispanic/Latino Black
- ☐ Hispanic/Latino More Than One Race
- ☐ Hispanic/Latino Unavailable/Unknown
- ☐ Hispanic/Latino White
- ☐ Middle Eastern/North African
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White/Caucasian
- ☐ Unavailable/Unknown

2. Preferred Language:

- ☐ English ☐ Urdu
- ☐ Spanish ☐ Tagalog
- ☐ Punjabi ☐ ASL
- ☐ Other: _____

3. Do you have difficulty receiving our services in English? ☐ Yes ☐ No

4. Marital Status

- ☐ Single ☐ Married
- ☐ Divorced ☐ Widowed
- ☐ Life Partner
- ☐ Legally Separated

5. a)Student Status

- ☐ Not a Student
- ☐ Part Time Student
- ☐ Full Time Student

5. b)Student at:

- ☐ _____ Unified School District
- ☐ _____ College/University
- ☐ Other (please specify)_____

6. Have you ever served in any branch of the armed services for any period of time, including the reserves?

- ☐ Army, Navy, Marines, Air Force, Coast Guard
- ☐ Not a Veteran

7. Current Gender

- ☐ Female
- ☐ Male
- ☐ Undifferentiated

8. Do you think of yourself as:
(Check one)

- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Lesbian, Gay, or Homosexual
- ☐ Something Else
- ☐ Don't Know
- ☐ Choose Not to Disclose

9. How do you identify yourself? (Check one)

- ☐ Male ☐ Female
- ☐ Transgender Male/Female-to-Male (FTM)/Trans Man
- ☐ Transgender Female/Male-to-Female (MTF)/Trans Woman
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional Gender Category, please specify:_____
- ☐ Choose not to Disclose

10. Is your current living situation stable? ☐ Yes ☐ No
Describe your current living situation: ☐ Home/Apartment ☐ Shelter ☐ Street/Camp ☐ Transitional ☐ Doubling Up (living with friends or family) ☐ Other: _____

(Please fill out a Care Link Eligibility Form if "No" or any box is checked in the box above)

11. Are you living in public housing? (*Section 8 is not considered Public Housing)* ☐ Yes ☐ No
If yes, please give name of agency/development: _____

12. In the last 2 years have <u>you or an immediate family member (Check all that apply):</u>
☐ **Worked in any type of agriculture** (farm work) – like planting, picking preparing the soil, packing house, driving a truck for any type of farm work, working with animals like cows, chickens, etc.?
☐ **Lived away from home in order to work in any type of agriculture** (farm work)?

13. Did <u>you or an immediate family member</u> stop migrating to work in agriculture (farm work) because of a disability or age (too old to work)? ☐ Yes ☐ No

FINANCIAL INFORMATION

Do you currently have health insurance? ☐ Yes ☐ No
If yes, Name of Insurance: _____ **Insurance #:** _____
Family Size: _____ **Family Income:** _____ ☐ **Monthly** ☐ **Annually**

RESPONSIBLE PARTY (Guarantor)
(*Statements/bills will be addressed to responsible party, if not covered by health insurance.***)**
Name: _____ **Date of Birth:** ____/____/____
Email: _____
Mailing Address: _____ **Apt.** ____ **City** _____ **State** _____ **Zip Code**_____
Home Phone: _____ **Cell:** _____ **Work Phone:** _____

<u>FOR MINORS (17 & UNDER) OR DEPENDENT ADULTS ONLY:</u>
Parent/Legal Guardian of Patient: _____ **Date of Birth:** _____
Relationship to Patient: _____
Parent/Legal Guardian of Patient: _____ **Date of Birth:** _____
Relationship to Patient: _____

<u>EMERGENCY CONTACT</u>
Name: _____ **Relationship:** _____
Phone: _____

SHARING INFORMATION

Please use this space to tell us who we are allowed to share, or release, information with.

Please leave this section BLANK if you do not want your information shared with ANYONE.

Person #1: _____
Relationship: _____
This person may:
☐ Share any and all of my medical information.
☐ Pick up my prescription medications in my absence.
☐ Send messages to my care team.
☐ Receive my test results.
☐ Schedule, Re-Schedule, or Cancel my appointments.

Person #2: _____
Relationship: _____
This person may:
☐ Share any and all of my medical information.
☐ Pick up my prescription medications in my absence.
☐ Send messages to my care team.
☐ Receive my test results.
☐ Schedule, Re-Schedule, or Cancel my appointments.

Print Name	**Signature of Patient/Legal Guardian**	**Date**

FOR OFFICE USE ONLY
Home Clinic: _____ **Data entered by:** _____ **Initials:** _____ **Date:** _____

COMMUNITY Medical Centers

General Medical Consent

PLACE LABEL HERE

Before you give your consent, be sure you understand the information given below. We will be happy to answer any questions you have. You may ask for a copy of this form.

Consent for Treatment: I request Community Medical Centers, Inc. (CMC) to provide me with health care services. I will be given information about the test(s), treatment(s), procedure(s), and medication(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I hereby request that a person authorized by Community Medical Centers, Inc. provide appropriate education, evaluation, testing, and treatment.

Community Medical Centers, Inc. (CMC) uses clinicians that are credentialed through CMC's board of Directors, and licensed through their respective boards in the state of California, including, but not limited to Physicians, Nurse Practitioners, Physician Assistants, Podiatrists, Optometrists, Physical Therapists, and Licensed Clinical Social Workers. I understand CMC may utilize certain telehealth technologies if appropriate. **If necessary, I will be given outside referrals for further diagnosis or treatment. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care.**

Release of Information: I understand that confidentiality will be maintained as described in *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described in *Notice of Health Information Privacy Practices*.

CMC participates in an electronic medical record exchange program and shares limited information about me with other health care facilities and providers that participate in the program for purposes of the delivery of care and services to me. I understand this exchange includes information, such as but not limited to, my name, date of birth, and contact information.

I understand that all services are confidential. In cases of life threatening emergencies and physical or sexual abuse, CMC may need to make a referral to another agency.

Interpretation Services: I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services will be provided if needed.

Use of Technology: I understand CMC uses a variety of electronic communication methods including phone, text messages, e-mail, to communicate with me for the limited purposes including of appointments, available services and other healthcare related communications. I understand that text and/or data charges may apply under my cell phone plan. I consent to allow CMC to use telehealth technologies for the purposes of the delivery of services to me. If I decide I do not want CMC to use telehealth technology as part of my care plan I will let my provider know.

Photography and Video: I understand that photographs, videotapes, digital and other images may be recorded to document my care, and I consent to this. I understand that these images will be stored in a secure manner that will protect my privacy.

Assignment of Insurance Benefit: I hereby authorize payment directly to CMC of benefits otherwise payable to me but not to exceed CMC's regular charges for this service. **I understand that I am financially responsible to CMC for any charges not covered by my insurance.**

Financial Agreement: I agree to pay all charges that are not payable by insurance or third party. I agree to abide by the terms and conditions of CMC's Collections Policy, and agree to pay for attorney fees or other expenses incurred in the collection of payment due.

In accordance with CMC's Collections Policy, CMC may choose to terminate its relationship with any patient who does not comply with this financial agreement.

Statement to Permit Payment of Medicare Insurance Benefits to CMC: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf.

Acceptance of Responsibility for Co-Payments: I understand that I am responsible for any health insurance deductibles or co- payments, including a twenty percent (20%) co-payment for authorized services covered by Medicare.

In the state of California minor patients (under the age of 18 years of age) may be allowed to consent to services without the parent/guardian being present, including emergency services, family planning services, and services related to sexually transmitted infections/diseases.

I hereby acknowledge receipt of Community Medical Centers, Inc. *Notice of Health Information Privacy Practices*. The undersigned certifies that he/she has read and understood the information above and authorizes services by Community Medical Centers, Inc. as the patient or as the patient's general agent and accepts its terms.

_____
Print Name

_____ _____
Signature of Patient or Legal Guardian **Date Signed**

Relationship to Patient (if applicable): ❑ Spouse ❑ Parent/Guardian ❑ Other: (specify)
_____

_____ _____
Minor Patient **Date Signed**

_____ _____
Witness **Date Signed**