REGISTRATION FORM

(The information on this form is required for our Federal Grant reporting and all patients must complete)

Patient Name: First	Middle:	Last:
If patient is a minor – name of responsible person #1 & DOB: Responsible for bill? ☐ Yes ☐ No	If patient is a minor – name of responsible person #2 & DOB: Responsible for bill? ☐ Yes ☐ No	
Date of Birth: Month/date/year / /	Patient's Social Security Number:	Marital Status: Please √ one: ☐ Single ☐ Married ☐ Other

Address: # and Street:	Apt.	City	State	Zip Code

Phone Numbers: Home: (___) _______________ Cellular: (___) _______________	Emergency contact name & Phone #: _________________________________	Occupation:
Gross Monthly Household Income $_____________ **Total Number in Family Supported by Income** ______________________________________	Does patient have an advanced directive? ☐ Yes ☐ No (If you would like more information about this, please let us know) Mother's Maiden Name:	

Sexual Orientation & Gender Identity

What sex were you assigned at birth on your original certificate? (Check one):	Do you think of yourself as:	What is your current gender identity? (Check one):	When addressing me, please use the following pronoun:
☐ Male ☐ Female ☐ Choose not to disclose	☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose	☐ Male ☐ Female ☐ Transgender Male/ Trans Man/Female-to-Male (FTM) ☐ Transgender Female/ Trans Woman/Male-to-Female (MFT) ☐ Genderqueer, neither exclusively male nor female ☐ Additional Gender Category/(or Other), please specify: ________ ☐ Choose not to disclose	**Pronouns:** ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other ______________

A. Is patient a veteran of the uniform services of the United States? ☐ Yes ☐ No

B. Is patient homeless or currently staying in an unstable temporary housing situation? ☐ Yes ☐ No

If YES to question B above, please answer this question by checking box ☐:

I would describe my living condition as: ☐ doubling up with friends, family neighbors ☐living in a homeless shelter or domestic violence center ☐living in transitional housing (transitional housing program) ☐living in a hotel, motel, Single Room Occupancy, Permanent Supportive Housing ☐living on the street or in your car or truck ☐living in an abandoned building, unheated garage, other unsafe building

If **YES to question B above**, please answer this question: Would patient be interested in a referral to our Transitions to Wellness program where free comprehensive services and case management is available to persons who are homeless or living in temporary living situations? ☐ Yes ☐ No

Which language does patient prefer to:		Speak	Read	Interpreter Needed?
	English	☐	☐	☐
	Spanish	☐	☐	☐
	Other	☐	☐	☐ __________________ (Identify language)

Race: Select all that applies to patient
☐ Asian ☐ Native Indian/Alaskan ☐ Pacific Islander
☐ Black/African American ☐ Native Hawaiian ☐ White
☐ Decline to State

Ethnicity: Please √ one:
☐ Hispanic/Latinx (H)
☐ Not Hispanic/Latinx (N)
☐ Decline to Specify

Insurance Status:
Does patient have health insurance right now? ☐ Yes ☐No

For insured patients: What type(s) of insurance? ☐ Medi-Cal ☐Covered California ☐ Medi-Care ☐Other (name)___________
Plan Name: _______________ Are you assigned to Northeast Valley Health Corporation? ☐Yes ☐No ☐ I don't know
Please have a copy of insurance card ready when you are called to register.

For uninsured patients: Patient may be eligible for a low income health program administered by LA County Dept of Health Services. Patient will need to bring in requested documents to apply for this program. Failure to bring in this information by the due date may result in all charges due and payable. Please discuss all options with a business office representative at this health center.

Are you interested in learning more about our sliding fee discount program?
This program is available to all eligible health center patients regardless of insurance status ☐ **Yes** ☐ **No**

FOR ADULTS ONLY:

Authorization to Release Medical Information to Family Members or Loved Ones

I, _____________________________, hereby authorize the following individuals to have access to my medical/dental records:

Name	Relationship	Birthdate	Entire Medical/Dental Record	Any Limitations?
__________________________	_________________	____________	☐ Yes ☐ No	___________________________
__________________________	_________________	____________	☐ Yes ☐ No	___________________________

How long would you like these individuals to have access to your medical / dental records for:
☐ 1 year ☐ No Time Limit ☐ Other ____

To review NEVHC Notice of Privacy Practices. Please visit: nevhc.org/resources-2/patient-resources-2/

Authorization For NEVHC To Contact Patient

Occasionally it is necessary for your care team to contact you or leave messages. The purpose of us contacting you is to remind you about appointments, discuss or schedule tests, referrals or call to discuss an issue or concern. We can reach you in a variety of ways. Please check all the ways in which we may contact you (CHECK ALL THAT APPLY):

☐ Email ___________________________@__________________
☐ Telephone # ____
☐ Text messaging # _____________________________________
☐ Mail
☐ NEVHC Patient Portal
☐ I have the following concerns about you contacting me: ____
____

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Date: ____/_____/______	Time: ___________	Acct. No:______________
Pt. Name:____________________________		Enc. No.:______________________
Address:____		
Home Phone: (___)_________________	Emerg No.:(_____)______-______________	
DOB_________ Sex________ Age_____	SSN:_______________________________	
Program:__________________________	Carrier Code:__________________________	
Medical-Cal No:_________________________________		
AFFIX PATIENT LABEL HERE		

GENERAL CONSENT

Please indicate your acceptance of each section by placing your initials on the line to the left.

________1. I, (name) ____________________________hereby consent to procedures which may be performed or provided by Northeast Valley Health Corporation (NEVHC) including emergency treatment which may include but are not limited to laboratory procedures, x-rays, medical, dental or surgical treatment or procedures rendered by a physician or dentist or by a nurse practitioner, physician's assistant or other staff performing under the supervision of a physician or dentist.

________2. I hereby authorize NEVHC to furnish my insurance carrier(s) with the necessary medical or dental record data required for completion of my insurance claims.

________3. I hereby irrevocably assign to NEVHC, payment for medical or dental services rendered to me and all medical or dental benefits.

________4. I understand that it is the policy of the health center that payment is due at the time services are rendered. Any other payment arrangement must be approved by the business office of NEVHC. I accept responsibility for ensuring payment of my account, whether on my own behalf or through insurance coverage. Should the account be referred to any attorney or agency for the purposes of collection, I agree to pay all attorney fees and expenses of collection.

________5. I consent to the taking of photographs, videotapes, digital or other images of my medical condition or treatment by clinical staff, and the use of the images for purposes of my diagnosis or treatment or for the clinic's operations including peer review, education and training programs conducted by the clinic.

________6. **For dental services**: In the event my dental provider refers me to a specialist, I understand it is my responsibility to follow through on the treatment plan. I also understand that I am fully responsible for the outcome and acknowledge failure to follow through on recommended care can lead to further complications and may even result in death.

________7. **For Family Planning:** I understand my use of family planning services is voluntary and that I have not been required to use family planning or reproductive health services in order to receive any other NEVHC services.

Signature of Patient/Parent/Guardian/Conservator: _______________________________________

Witness: ______________________________ Date: _______________________________

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ACKNOWLEDGEMENT OF RECEIPT
Reconocimiento de Recibo

The following patient information was discussed with me and I have been given the option to receive a copy of each of the items listed below or I can view information online at:
http://www.nevhc.org/resources/patient-resources.html

La siguiente información se me ha explicado y he me ha dado la opción de recibir una copia de los siguientes artículos mencionados a continuación o yo puedo ver la información en la página de internet en: http://www.nevhc.org/es/recursos/recursos-para-pacientes.html

☐ Advanced Medical Directives
Instrucciones Médicas Anticipadas

☐ Patient Rights
Derechos del Paciente

☐ Patient Responsabilities
Responsabilidades del Paciente

☐ Patient Complaints & Suggestions
Quejas y Sugerencias del Paciente

☐ Code of Ethics Summary
Resúmen del Código de Etica

☐ Important Patient Policies
Importantes Pólizas Sobre el Cuidado del Paciente

☐ Summary of Notice of Privacy Practices
Resumen de la Notificación de Nuestras Prácticas de Confidencialidad-NEVHC

☐ Patient Grievance Procedure
Procedimiento de Quejas del Paciente

☐ Appointment Policy
Póliza sobre las Citas

Other:

☐ Therapeutic Monitoring Program NPP ***(Van Nuys Adult Only)***
Programa de Pruebas de Diagnóstico

☐ Dental Materials Fact Sheet from the California Dental Association ***(Dental Only)***
Hoja de Datos Materiales Dentales del Consejo Dental de California

Printed Name/Nombre Escrito: ____

Signature/Firma: ____

Witness/Testigo: ____

Date/Fecha: ____

Attachment 1 English

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Patient/Provider Appointment Agreement

Dear Patient/ Parent/Guardian:

Medical care and treatment works best when the provider and the patient work together. As a patient, it is your responsibility to come to all the appointments you have made with us. Northeast Valley Health Corporation (NEVHC) gives a time slot to each patient to see his/her provider. We have a high demand for our medical services. To serve all of our patients and give the best possible care, it is very important that you keep your appointment time.

- If you need to cancel or change your appointment, please let us know at least 24 hours before your appointment time.
- You can call the Call Center at (818) 270-9777 / (661) 705-2040 to cancel or change your appointment.
- If you miss appointments, you may receive a warning from your provider. A missed appointment can be failing to show up or failing to call in to change or cancel your appointment.
- Once you have received a warning, and miss more appointments, you may be terminated from medical care services at NEVHC.

I have read and understand the Appointment policy as described above and agree to follow this policy:

________________________________ MR#_________________________
Patient's Name

________________________________ Date: _________________
Patient/Parent/Guardian Signature

Original: Medical Record Copy: Patient