Northeast Valley Health Corporation
a california health+ center

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 parent / legal guardian #1 & DOB: Responsible for bill? ☐ Yes ☐ No	If patient is a minor – name of parent / legal guardian #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 #: _____		Patient's 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) ☐ Single Room Occupancy (SRO) ☐Living in a hotel or motel, ☐ 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**

Authorization to Release Medical Information to Family Members or Loved Ones (ADULTS ONLY)

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 _____

-- OR—

☐ I do not have anyone or do not wish to give anyone authorization to access my medical/dental records. _____(initial)

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 (Title X):** 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. A referral by a physician is not required to receive family planning services. Family planning services are provided by NEVHC regardless of state (durational) residency, citizenship or immigration status.

Signature of Patient/Parent/Guardian/Conservator: _____

Relationship to the Patient: _____

Witness: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT
Reconocimiento de Recibo

The following patient information was provided to me by providing me with a copy of the NEVHC Patient Handbook which can be viewed at:
https://nevhc.org/wp-content/uploads/2023/03/NEVHCPatientHandbookEng2023-3.pdf
or the QR Code below.

La siguiente información se me ha explicado y se 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:
https://nevhc.org/wp-content/uploads/2023/03/NEVHCPatientHandbookSpan2023-3.pdf
o con el código QR

English

Spanish

- ☐ Advanced Medical Directives
  Instrucciones Médicas Anticipadas
- ☐ Patient Rights
  Derechos del Paciente
- ☐ Patient Responsibilities
  Responsabilidades del Paciente
- ☐ Patient Complaints & Suggestions
  Quejas y Sugerencias 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:

- ☐ 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: _____

Date/Fecha: _____

Attachment 1 English

Northeast Valley Health Corporation

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

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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	

Patient Change of Consent Form-Health Information Exchange

Please use this form only if you wish to change your current consent status regarding your permission allow NEVHC to share your information with clinicians who have a test or treatment relationship with you.

Please check the box next to your choice changing your status to be in the Exchange. Please Sign the form at the end. Each family member should fill out a separate form.

☐ **Choice 1:** **I do not agree** to have my medical information viewed in the Exchange.

☐ **Choice 2:** **I want to change an earlier decision not to join the Exchange.** I now agree to have my medical information viewed in the Exchange. This may include information from before today's date.

Please sign here:

Signature

_____Date_____

Complete this information only if you have signed the form for another person:

Do you have the authority to make health care decisions on behalf of the patient? ☐ Yes ☐ No

What is your relationship with the patient? _____

This section for office use only:

Verified by: _____

Signature of verifying staff: _____

Date: _____

NEVHC SUMMARY OF NOTICE OF PRIVACY PRACTICES (2020)

This is a summary of the Northeast Valley Health Corporation (NEVHC) Notice of Privacy Practices. You have a right to receive a copy of the complete document.

NEVHC recognizes that your medical information is personal. We are committed to providing privacy and confidentiality of your medical information. This summary notice briefly describes NEVHC's privacy practices and the way in which we may use and disclose medical information about you.

We are required to maintain a complete copy of your medical history, current condition, treatment plan and all treatment given, including the results of all tests, procedures and therapies. We must maintain this information in a safe and secure manner that protects your privacy and confidentiality. With a few exceptions (described in the complete NEVHC Notice of Privacy Practices), we are prohibited from selling your medical information without first obtaining your authorization to do so. You have the right to read or get a copy of your medical information in most circumstances.

Communications with your NEVHC Care Team: NEVHC offers all patients the ability to sign up for the NEVHC portal. This portal is a secure HIPAA complaint website for you to view your medical information, communicate with your care team, review diagnostic test results and pay your NEVHC bill. No one else except you and your NEVHC care team have access to your portal unless you share your personal password. Healthcare information that is exchanged by patients through their personal e-mail is not secure.

NEVHC May Use and Disclose Medical Information about You in the Following Ways:

1. **At Your Request:** We may disclose information when requested by you to do so, and sometimes this may require you to sign a written authorization. We may also charge a fee for this release as permitted by law.
2. **For Treatment:** Other health professionals within or outside of NEVHC who are involved in your care may need to access your information in order to provide you with appropriate care.
3. **For Payment:** To bill or collect for payment of services from you, your insurance company, or a third party billing agency, we may disclose your information.
4. **For Healthcare Operations:** We may use or disclose medical information about you to the extent necessary to run the facility or ensure quality care.
5. **For Research:** Patient records and medical information are valuable tools used by researchers to discover new treatment options, and we may disclose your information so that others may use it to study healthcare. If we do so, we will remove information that identifies you, unless otherwise required or permitted by law.
6. **Appointment Reminders:** We may use your information to contact you as a reminder that you have a scheduled appointment.
7. **Treatment Alternatives, Health-related Benefits and Services:** We may use or disclose medical information to tell you about or recommend possible treatment options, alternatives to your current treatment, or health-related benefits or services that may be of interest to you.
8. **To Avoid Serious Threat to Health or Safety:** When necessary, your information may be used or disclosed to prevent a serious threat to the health and safety of you, the public or another person.
9. **Public Health Risks:** We may disclose medical information about you for public health activities to prevent or control disease, injury or disability; to report births and deaths; to report child abuse and/or neglect; to report reactions to medications or problems with products; to notify people of recalls of products; to notify a person that they may have been exposed to a disease or may be at risk for contracting or spreading a disease; and to notify a government agency about abuse, neglect or domestic violence as required by law.
10. **Health Oversight Activities:** We may disclose your medical information to a health oversight agency for lawful oversight activities, such as audits or inspections.
11. **Worker's Compensation:** We may release medical information about you for worker's compensation benefits for work-related injuries or illnesses.
12. **Specialized Government Functions:** We may release your medical information pursuant to specialized government functions, such as military activities, national security and intelligence activities, protective services for the President and others, and correctional institutions and other law enforcement custodial situations. For example, if you are a member of the armed forces, we may release information about you as required by military command authorities.

13. **Fundraising Activities:** We may use medical information about you to contact you in an effort to raise money for the facility and its operations, but we will only release contact information about you and/or the dates you received treatment or services from us.
14. **Judicial and Administrative Proceedings; Law Enforcement:** We may release information about you if asked to do so by a law enforcement official or in the course of a judicial or administrative proceeding in various ways, such as in response to a court order, subpoena, warrant, summons; to identify or locate suspect, fugitive, material witness or missing person; about a victim of crime; about a death as a result of a crime; about criminal conduct at our clinic; and in emergency circumstances to report a crime.
15. **Coroners, Medical Examiners and Funeral Directors:** We may release medical information about you to a coroner or medical examiner to identify a deceased person or determine cause of death. We may release information to funeral directors as necessary to carry out their duties.
16. **Victims of Abuse, Neglect or Domestic Violence:** We may disclose your medical information to a government authority if we reasonably believe that you are a victim of abuse, neglect, or domestic violence.
17. **Organ, Eye or Tissue Donation:** We may use or disclose your medical information to appropriate organizations for the purpose of facilitating organ, eye, or tissue donation and transplantation.
18. **Health Information Exchange:** This is a secure computer network to share and gather important medical information about you with other health care providers and care team members who you see in a variety of health care settings. Only staff involved in your care has access to this information for the purposes of coordinating your health care. **Unless you specifically tell us you want to OPT OUT your medical information will be shared via an HIE**
19. **As Permitted or Required by Law:** We may release your information as permitted or required by California and/or federal law.

Except as permitted or required by law, we do not allow others outside of NEVHC to access your medical information unless we have authorization from you to do so. Any authorization to use or disclose medical information may be revoked by you in writing at any time unless: (1) NEVHC has already taken action in reliance on that authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage.

In certain specific circumstances (described in the complete NEVHC Notice of Privacy Practices) as required by law, we will inform you in advance of a use or disclosure and give you the opportunity to prohibit or restrict that use or disclosure. Whenever specific patient permission is required to use or disclose your information, we will not use or disclose that information without first obtaining your specific permission.

YOU HAVE THE FOLLOWING RIGHTS REGARDING MEDICAL INFORMATION WE MAINTAIN ABOUT YOU:

1. You have the right to inspect and receive a copy of your medical information except in limited circumstances.
2. You have the right to amend your medical information if you believe it is incorrect or incomplete (restrictions may apply).
3. You have the right to request restrictions or limitations of your medical information, but we are not required to agree.
4. You have the right to request the method by which we communicate with you about medical matters so that the communication is kept confidential. We will accommodate all reasonable requests.
5. You have a right to receive an accounting of certain disclosures that we have made of your medical information.
6. You have a right to receive a paper copy of the complete NEVHC Notice of Privacy Practices.

FILING A COMPLAINT:

If you wish to request restrictions, amendments or accountings of your medical information, you may file such a request in writing with the NEVHC Privacy Officer located at 1172 North Maclay Avenue, San Fernando, CA, 91340. You may also send an e-mail to privacyoffice@nevhc.org or call (818) 898-1388.

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer of NEVHC or with the Secretary of the Department of Health and Human Services. To file a complaint with the Secretary, you can ask NEVHC's Privacy Officer for the appropriate contact information, or you can visit www.hhs.gov/ocr for further information on how to file a complaint. All complaints must be in writing. You will not be penalized in any way for filing a complaint.