Long Valley Health Center

Acct# Patient Information Sheet and Consent Form

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Previous Last Name: _____ Sex: ☐ Male ☐ Female

Social Security #: _____ Date of Birth: _____/_____/_____

Mailing Address: _____City: _____State: _____ Zip Code: _____

Home Address (if different than mailing): _____City: _____State: _____ Zip Code: _____

Please check preferred contact method:

Phone: ☐ Home: _____ ☐ Work: _____ ☐ Cell: _____

(Okay to leave a message? ☐ Yes - ☐ Brief ☐ Detailed ☐ No)

E-mail address: _____ ☐ No E-mail address

Primary (Preferred) Language**:** ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Single w/partner ☐ Divorced ☐ Separated ☐ Widow(er)

Employer: _____ Address: _____Work Phone: _____

Pharmacy: _____

Primary Care Provider:

☐ Dr. Tom Bertolli ☐ Dr. Sharon Paltin ☐ Kathleen Sharpe, FNP ☐ Carrie Guilfoyle, ANP-C

☐ Other:_____

In case of emergency, please contact:

Name: _____

Phone: _____Relationship:_____

Additional Patient Information (please answer all questions):

By answering the following questions, you will give us information we need to acquire funds to help uninsured and underinsured residents in our community. This information also helps us recognize clients who may qualify for specially funded programs or services.

Sexual orientation and gender identity can play a significant role in determining health outcomes. Asking these questions also improves patient centered care.

Sexual Orientation (Please check one)

☐ Straight/Heterosexual ☐ Gay, Lesbian, Homosexual ☐ Bisexual ☐ Don't Know ☐ Other ☐ Decline to specify

Gender Identification (Please check one)

☐ Female ☐ Male ☐ Female to Male/Transgender ☐ Male to Female/Transgender ☐ Other ☐ Decline to specify

Race (Please check one): ☐ White (including Hispanic / Latino) ☐ Black/African American ☐ Asian

☐ American Indian / Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other:_____ ☐ Decline to specify

Ethnicity (Please check one): ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Unreported /Refused to Report

Homeless ☐ YES ☐ NO

If yes, currently living in: ☐ Shelter ☐ Street / Campground ☐ Transitional Housing ☐ Doubling Up (Family or Friend)

Farmworker ☐ YES ☐ NO If yes: ☐ Migrant ☐ Seasonal

Current or Discharged Veteran ☐ YES ☐ NO

Family Size: _____Household Income: $_____ ☐ Annual ☐ Monthly

OVER (Please complete other side)

Primary Insurance:

☐ Medi-Cal ☐ Partnership ☐ CMSP ☐ Medicare

☐ Any Other Coverage_____ (Blue Cross, Blue Shield, Delta, etc.)

ID/Subscriber #: _____ Plan/Group #_____

Mailing Address: _____City: _____State: _____ Zip Code: _____

Subscriber Name: _____ Subscriber Date of Birth_____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance:

☐ Medi-Cal ☐ Partnership ☐ CMSP ☐ Medicare

☐ Any Other Coverage: _____ (Blue Cross, Blue Shield, Delta, etc.)

ID/Subscriber #: _____ Plan/Group #_____

Mailing Address: _____City: _____State: _____ Zip Code: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

If patient is a minor, complete this section.

Responsible Party:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to patient: _____ Phone: _____

Address (if different): _____ Date of Birth: _____

City: _____State: _____ Zip Code: _____ Social Security #: _____

Employer: _____ Address: _____ Work Phone: _____

Mother's/Guardian's Name: _____ Date of Birth: _____

Address (if different): _____ Phone: _____

Father's/Guardian's Name: _____ Date of Birth: _____

Address (if different): _____ Phone: _____

1. Release of Information: To the extent necessary to determine the liability for payment and to obtain reimbursement, I authorize Long Valley Health Center to release portions of my medical records to any person, organization, or agency which is or may be liable for all or any portion of LVHC's charges, including but not limited to insurance companies, health service plans, workers' compensation carriers and government agencies. The Dept. of Health Services may audit my medical records for the purpose of Center licensing or for statistical information. Such audits and or release of records will not compromise the confidentiality of my medical record.

2. Financial Agreement: I hereby agree, in consideration of services rendered by Long Valley Health Center, to pay all bills as presented regardless of insurance coverage. I agree, that if it becomes necessary, the account will be referred to a collection agency and I shall pay the collection expenses in full.

3. Consent for Treatment: I, the undersigned, consent to the medical/dental examination, immunizations, treatment and procedures for the care of the above named Patient. I understand that Physician Assistants/Nurse Practitioners (PA/NP) have been approved by the State of CA to dispense drugs and medical supplies on the direct order of a physician or according to previously established written guidelines and that, a physician is always available to the PA/NP for consultation during the assessment and treatment of patients. To assist medical/dental providers to safely prescribe medication and administer immunizations, I consent to their access to the patient's prescription medication history and immunization records.

Signature: _____ **Date:** _____ **Relationship to Patient:** _____

Office Use: _____ ***Date:*** _____ ***Title:*** _____