PATIENT REGISTRATION FORM

Valley Family Health Care (VFHC) is a Federally Qualified Health Center and receives federal funding pursuant to Section 330 of the Public Health Service Act. We are required to collect information about age, gender, race, sexual orientation, income, and family size for statistical purposes only. No individual information is submitted.

PATIENT INFORMATION

Name: First	Middle	Last	
Birthdate: / /	SSN(opt.):	Birth Gender: ☐ Male ☐ Female	
Preferred Name:	Email Address:		
Physical Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone: Text Message Ok? ☐ Yes ☐ No	Cell Phone: Text Message Ok? ☐ Yes ☐ No	Work Phone: Text Message Ok? ☐ Yes ☐ No	

What is your preferred language? ☐ English ☐ Spanish ☐ Other (specify): _____

The contact information provided above may be used to contact your phone, text, or email to communicate information including appointments, billing, clinic and provider changes, patient portal, prescriptions, your health status, and marketing. Tell staff if you have communication preferences.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐ Partner

Housing Status: Are you homeless? ☐ Yes ☐ No If yes, which best describes where you stay? ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Unknown ☐ Other: _____

Sexual Orientation: ☐ Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Other ☐ Unknown ☐ Choose not to disclose	Gender Identity: ☐ Male ☐ Female ☐ Genderqueer ☐ Transgender Female: *Male-to-Female* ☐ Transgender Male: *Female-to-Male* ☐ Other ☐ Choose not to disclose

EMPLOYER INFORMATION

Please Check One Option: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Child

Employer Name:	Employer Phone:

GUARANTOR – PERSON PAYING FOR YOUR VISIT

Name: First	Middle	Last	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____		Birth Date: / /	
Preferred Phone:	Email Address:		
Address:	City:	State:	Zip:
Employer:	Employer Phone:		

EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:

PERSONAL REPRESENTATIVES

Please list individuals allowed to know your health information:

1. Printed Name_____Address_____Phone_____
   Select: ☐ Verbal ☐ Request/Receive Medical Records ☐ Receive Medications/Prescriptions
2. Printed Name_____Address_____Phone_____
   Select: ☐ Verbal ☐ Request/Receive Medical Records ☐ Receive Medications/Prescriptions
3. Printed Name_____Address_____Phone_____
   Select: ☐ Verbal ☐ Request/Receive Medical Records ☐ Receive Medications/Prescriptions

This information will be updated with your annual registration and can be revoked at any time by you. We do not condition treatment or eligibility on completion of this information. Protected Health Information released has the potential of redisclosure by the recipient and is then no longer protected by Valley Family Health Care. Signing this registration form indicates your approval of this information sharing.

INSURANCE INFORMATION (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Primary Medical Insurance	Secondary Medical Insurance	Dental Insurance
Name of Insurance:	**Name of Insurance:**	**Name of Insurance:**
Policy Number:	**Policy Number:**	**Policy Number:**
Group Number:	**Group Number:**	**Group Number:**
Subscriber Name:	**Subscriber Name:**	**Subscriber Name:**
Subscriber Birthdate: / /	**Subscriber Birthdate:** / /	**Subscriber Birthdate:** / /
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other

Please turn over →

ACKNOWLEDGMENTS

AUTHORIZATION FOR TREATMENT

I authorize Valley Family Health Care (VFHC) to conduct a medical, dental, and/or mental health evaluation and make treatment recommendations for myself or my dependent. I realize that no guarantee has been made as to the outcome of my treatment. I understand that VFHC maintains an educational program for healthcare students which includes clinic rotations to provide supervised patient care activities. I understand that I will be informed when a student is part of my care and given the opportunity to decline their participation. By authorizing treatment, I am providing consent for VFHC to access and maintain my past and current medical records including but not limited to medications, surgical procedures and diagnostic studies through a variety of sources, including pharmacies, health insurers and other healthcare providers to provide me with the highest quality and safest care possible. I authorize VFHC to contact me via phone, text or email to communicate information including appointments, billing, clinic and provider changes, patient portal, prescriptions, your health status, and marketing.

Telehealth Informed Consent- Telehealth is a visit with a health care provider which uses video conferencing software or even your telephone to connect to your provider. When using video conferencing, both you and the provider will use a camera and speakers to communicate with each other about your healthcare. By signing this form below, you are attesting that you have read and understand the document titled "Informed Consent Telehealth Services" and agree to participate in telehealth services with VFHC. Our staff are available to answer any questions you may have.

AUTHORIZATION TO BILL INSURANCE AND ASSIGNMENT OF BENEFITS

The information provided on this registration form is true to the best of my knowledge. I authorize VFHC to directly bill my insurance company and any third-party payer through which I have benefits to make payment directly to VFHC. I authorize VFHC or insurance company to use and disclose any healthcare information to obtain payment for services and determining insurance benefits. Services provided by outside companies, (i.e., lab, pathology, radiology) are billed separately by those companies.

FINANCIAL AGREEMENT

I understand and agree to the following: *Please feel free to discuss payment issues with us, we want to help.*

- Payment is expected on the day of service. I will be asked to submit some form of payment (can be insurance) on the service date.
- I can complete a Sliding Fee Discount Program Application (even if I have insurance).
- VFHC may bill my insurance as a courtesy to me.
- I am responsible for all charges, including deductibles, co-pays, and services not covered by insurance.
- VFHC sends monthly statements to patients with balances, which include unpaid amounts processed through insurance.
- Any payment I make will be applied to my balance and may not cover all services.
- VFHC may create payment plans for patients who can't pay the amount owed.
- Unpaid account balances may be turned over to a collection agency after 90 days.
- If I can't pay my bill, I will contact the **VFHC Billing Department at 208-642-6989**.

MISSED APPOINTMENTS POLICY

Valley Family Health Care values your relationship with us, which includes attending scheduled appointments. Please note the following policy:

- Please call your VFHC clinic at least 1 day ahead of time if you need to reschedule your appointment.
- If you miss 2 scheduled appointments within a year, you may receive a referral to our Community Health Workers to help with issues (transportation, finances, insurance) that make it difficult to get to your appointments.
- If you miss 3 scheduled appointments within a year, you will be seen as a walk-in patient only, waiting until the provider is available.
- After 1 walk-in visit, you may schedule appointments again.

As a Federally Qualified Health Center, we are <u>required</u> to collect the following information to help us improve care and lower costs for all. Your personal information is <u>not</u> shared. Please help us by answering the following questions below.

Family Income	Our annual household income before taxes is: $ _____ . ☐ Choose not to disclose	There are #_____ people in my household (including myself).	
Sliding Fee Discount	Are you interested in applying for our reduced fees, even if you are insured?	☐ **Yes**	☐ **No**
Ethnicity	Are you Hispanic/Latino?	☐ **Yes**	☐ **No**
Race	☐ White ☐ Black/African American ☐ Asian ☐ Hawaiian Native ☐ Pacific Islander ☐ American Indian/Alaska Native ☐ More than 1 ☐ Choose not to disclose		
Farmworkers	**In the past two years**, have you or a member of your family worked in agriculture (fields, orchards, etc.) as the primary source of income?	☐ **Yes**	☐ **No**
	If yes, does this person change residence as part of his work?	☐ **Yes**	☐ **No**
Veterans	Are you a Veteran?	☐ **Yes**	☐ **No**

I certify that the information provided on my registration form is complete and accurate to the best of my knowledge. I have read, understand and been offered a copy of the following: **Notice of Privacy Practices** *(posted) I understand that VFHC participates in statewide data exchanges and registries and that I read details about the information shared and how I can opt out in the posted notice;* **Authorization for Treatment** *(above);* **Telehealth Consent** *(posted)***; Authorization to Bill Insurance and Assignment of Benefits** *(above);* **Financial Agreement** *(above);* **Missed Appointments Policy** *(above)*

X Patient/Guardian Signature:_____ Date: _____ VFHC STAFF:

We comply with applicable Federal civil rights laws and do not discriminate based on race, color, ethnicity, citizenship status, national origin, gender, gender identity, sexual orientation, age disability, religion, or any status protected by law.

No patient will be denied care based on inability to pay.