La Clínica

❑ La Clínica de La Raza ❑ San Antonio Neighborhood Health Center ❑ Clínica Alta Vista
❑ La Clínica Oakley ❑ La Clínica Pittsburg ❑ La Clínica Monument
❑ La Clínica Vallejo ❑ La Clínica North Vallejo ❑ La Clínica Vallejo Great Beginnings

PATIENT I.D. CARD
PATIENT NAME _____
MR# _____ DOB _____ M F
PRIMARY PROVIDER _____ DATE _____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: Last: _____ First: _____ MI ___ Other Name(s) used: _____

Nickname: _____ Social Security Number: _____ - _____ - _____ Date of Birth: _____/_____/_____

Sex: ❑ Male ❑ Female ❑ Transgender

Mailing Address: _____ City: _____ State: _____ Zip: _____

What is the patient's primary language? _____

May we contact you by phone? ❑ Yes ❑ No If yes, may we leave a ❑ brief or ❑ extended message on your phone?

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner

Student: ❑ Yes ❑ No If yes, ❑ Full-time ❑ Part-time

Phone (home): _____ (work): _____ Cell _____

INSURANCE INFORMATION

Primary Insurance Company Name	Insured Member Name	DOB	Insurance ID#

Medi-Cal ID# _____ Medicare ID# _____

Secondary Insurance Company Name	Insured Member Name	Insurance ID#	Insured Employer

Employed: ❑ Yes ❑ No If yes, ❑ Full-time ❑ Part-time

Employer: _____ Address: _____

Preferred Pharmacy: _____ Address: _____ Phone Number: _____

RESPONSIBLE PARTY (if patient is a minor complete this section)

Name: Last: _____ First: _____ MI: _____

Relationship to patient: _____ Phone (home): _____ (work): _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____ Employer: _____

EMERGENCY CONTACT

Name: _____ Phone Number (home): _____

Relationship to patient: _____ Phone Number (work): _____

ADDITIONAL PATIENT INFORMATION (please answer all questions)

La Clínica is a non-profit organization committed to serving the needs of our community. By answering the following questions, you will provide us with information we need to acquire grant funds to help uninsured and underserved residents in our community. This information also helps us recognize clients who may qualify for specialty funded programs or services. Please help us by providing us with this information. This information will become a part of your confidential medical record.

a) Has patient been homeless at any time since January of this year? ❑ Yes ❑ No
If yes, ❑ Homeless Shelter ❑ Doubling Up ❑ On Street ❑ Unknown

b) What type of work does the patient do? (Please check one): ❑ None ❑ Professional ❑ Clerical ❑ Sales ❑ Service ❑ Laborer ❑ Agriculture
If Agriculture: ❑ Employed year round ❑ Migrant ❑ Seasonal ❑ Unemployed

c) Preferred spoken language? ❑ English ❑ Spanish ❑ Other _____ Do you require an interpreter? ❑ Yes ❑ No

d) Do you reside in public housing? ❑ No ❑ Tenant Based housing ❑ Other (please specify) _____

e) Race (please check one): ❑ African American/Black ❑ American Indian/Native American ❑ Alaska Native ❑ Asian ❑ Caucasian/White ❑ Native Hawaiian ❑ Other Pacific Islander ❑ More than one Race ❑ Other (please specify) _____

f) Ethnicity (please check one): ❑ Hispanic ❑ Non-Hispanic

g) Are you a Veteran? ❑ Yes ❑ No

h) Number of people in patient's household: _____ Monthly household gross income (approximate): $_____

PAYMENT INFORMATION

La Clínica is a non-profit organization. We depend on your prompt payment for services so that we can continue to provide high quality, low-cost care for our community. We require payment at the time of service unless arrangements have been made with our billing department prior to the visit. We will bill your primary insurance carrier, but we do require you to pay your co-payment and any deductible you have not met at the time of service. We will bill supplemental insurance for our Medicare patients. Any amounts due after your insurance pays its portion will be billed to you. Payment is due upon receipt of your statement. You will be required to present your insurance card at each visit. _____ (initials).

CONSENTS

In order to provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initializing the areas indicated and by providing your signature below.

Assignment of Benefits/Financial Agreement: I authorize payment for all medical benefits to La Clínica for professional services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default; I agree to pay all costs of collection, and reasonable attorneys fees. _____ (initials).

Release of information: I authorize the release of all information necessary to secure the payment of benefits related to my care. I further agree that a photocopy or digital image of this agreement shall be as valid as the original. _____ (initials).

CONSENT OF TREATMENT

I hereby authorize and consent to procedures necessary for diagnosis and treatment for myself and my family while a patient at La Clínica. _____ (initials)

AUTHORIZATION TO REVIEW PHARMACY HISTORY

I hereby authorize La Clínica to view my prescription history from outside sources. _____ (initials).

Your signature below indicates you have read, understand and agree to the above consents and to the patient rights and responsibilities.

Signed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

La Clínica is committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices States:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

I hereby acknowledge that I have received/been offered a copy of the Notice of Privacy Practices.

Signed: _____ Date: _____

Parent/Patient's Representative: _____ Date: _____

_____

Description of Legal Authority to Act on Behalf of Patient

Thank you for choosing La Clínica and for your help in assuring that quality care is available in our communities.