CLINICA DE SALUD DEL VALLE DE SALINAS

☐ Administration	☐ Circle	☐ Sanborn	☐ Castroville	☐ Soledad	☐ Greenfield	☐ King City
55 Plaza Circle Suite A Salinas, CA 93901 (831) 757-8689 FAX: (831) 757-0488	950 Circle Drive Salinas, CA 93905 (831) 757-6237 FAX: (831) 757-8458	219 N. Sanborn Road Salinas, CA 93905 (831) 757-1365 FAX: (831) 757-2824	10521 Merritt Street Castroville, CA 95012 (831) 633-1514 FAX: (831) 633-1739	799 Front Street Soledad, CA 93960 (831) 678-0881 FAX: (831) 678-2803	808 Oak Street Greenfield, CA 93927 (831) 674-5344 FAX: (831) 674-5214	223 Bassett Street King City, CA 93930 (831) 385-5944 FAX: (831) 385-0767
		☐ Plaza 55 Plaza Circle Suite C Salinas, CA 93901 (831) 500-6960 FAX: (831) 758-2201	☐ Gonzales 126 5th Street Gonzales, CA (831) 675-2930 FAX: (831) 675-2931	☐ Pajaro 29-A Bishop Street Pajaro, CA (831) 728-2508 FAX: (831) 728-2636	☐ N. Main 2180 N. Main Street Salinas, CA 93906 (831) 443-2190 FAX: (831) 442-3600	

Patient Name_____ **Date of Birth**_____ **Chart Number** _____

PATIENT CONSENT

I hereby consent to any medical or surgical treatment for myself or my minor child. I understand that even simple treatment or diagnostic measures have a risk of complications which will be explained at the time of the procedure or treatment. Referrals will be made for specialized services that Clinica de Salud is unable to provide.

I understand and give my consent to be attended by a Resident Physician/ Nurse Practitioner or Physician Assistant instead of a board certified doctor. I also understand that the same Nurse Practitioner or Physician Assistant may be prescribing my medicines. They are certified to do so under the supervision of a physician. If I wish, I can be attended by a Doctor and have my medicines prescribed by the doctor.

I understand that any portion of my medical records shall be open for inspection by the State, insurers, and other regulatory or clinical agencies upon request will be provided access to all data collected under the terms of their contracts with Clinica de Salud. These records and data will be subject to fiscal and program audits and will not be public in any manner which allows identification of any individual.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how may private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that Clinica de Salud offers a family discount program for office visits where charges are made according to family size and income. The family discount program applies to services provided at the clinic. I understand that I am responsible to provide CSVS with the appropriate insurance and/or income information and I will be personally responsible for the amount not covered of the services received in accordance with CSVS fee schedule.

Patient or Legal Guardian_____
(Signature)

Witness_____ **Date**_____ **Time**_____
(Signature)

CLINICA DE SALUD DEL VALLE DE SALINAS
Patient Information

Date:_____ MRN:_____
Account #: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____
Do you have a language barrier? ☐ Yes ☐ No
Place of Birth:_____

Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	Phone Number

Ethnicity	Email	Sex
☐ Hispanic ☐ Black ☐ White ☐ Other:_____		☐ F ☐ M

Gender Identity ☐ Female ☐ Male
☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Choose not to disclose
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Additional gender category or other, please specify _____
☐ Genderqueer, neither exclusively male nor female

Sexual Orientation ☐ Bisexual ☐ Lesbian, gay or homosexual
☐ Choose not to disclose ☐ Something else, please describe: _____
☐ Don't Know ☐ Straight or heterosexual

Mailing Address	City	State	Zip Code

Employer Name	Work Phone Number	Occupation

In case of an emergency call:	Phone Number

Responsible Party
Information of Person Financially Responsible
(Parent if patient is under 18)
If different from above

Last Name	First Name	Middle Initial

Date of Birth	Social Security #	Phone Number	# of Dependents (family size) :____

Employer Name	Occupation

Insurance Information
Please provide the staff with your insurance card

Carrier's Name	Policy #	Group #	Relation to Patient

Carrier's Address	Subscriber

City	State	Zip Code	Telephone

FOR OFFICE USE ONLY:

Monthly Salary_____Do you work all year: ☐ yes ☐ no If No, Months not Worked:_____

How do you support your family when not working?_____

How was income information verified? ☐ Income Tax Statement ☐ Check Stubs (Previous 6 months)

Patient's Migrant Status: ☐ Migrant ☐ Seasonal ☐ NOT Farm Worker

Patient's Homeless Status: ☐ Not Homeless ☐ Doubling up ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown/Unreported

Category: ☐ Private ☐ INS ☐ SOFP ☐ IM ☐ Medi-Cal ☐ EAPC ☐ BCCP ☐ H.F. ☐ MO ☐ MM ☐ CCA

For office use Only: ❒ Patient information updated on EPM including scanning of Insurance information
Date/ Initial this form when completed

Date Completed:_____Initials: _____

Patient Responsibilities

1. **Providing Information** - Patients and families, as appropriate, must provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matters relating to their health. Patients and their families must report perceived risks in their care and unexpected changes in their condition. They can help the organization understand their environment by providing feedback about service needs and expectations.

2. **Asking Questions** - Patients and families, as appropriate, must ask questions when they do not understand their care, treatment, and service or what they are expected to do.

3. **Following Instructions** - Patients and their families must follow the care, treatment and service plan developed. They should express any concerns about their ability to follow the proposed care plan or course of care, treatment, and services. The organization makes every effort to adapt the plan to the specific needs and limitations of the patients. When such adaptations to the care, treatment, and service plan are not recommended, patients and their families are informed of the consequences of the care, treatment, and service alternatives and not following the proposed course.

4. **Accepting Consequences** - Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan.

5. **Following Rules and Regulations** - Patients and their families must follow organization's rules and regulations.

6. **Showing Respect and Consideration** - Patients and their families must be considerate of the organization's staff and property, as well as other patients and their property.

7. **Meeting Financial Commitments** - Patients and their families should promptly meet any financial obligation agreed to with the organization.

I understand that Clinica de Salud has agreed to provide services that are available to members of my medical/dental/optometry plan. In the event that my membership cannot be verified, or is denied for any reason, I will be personally responsible for the value of the services received in accordance with CSVS fee schedule.

Patient Signature (Parent or Guardian)

Name (Please Print) **Date of Birth**

Date **Medical Record Number**