GREATER VALLEY
HEALTH CENTER

Patient Intake Form

Some of this information is gathered for our grant and grant reporting.

No individual information will be shared. The grant helps us to serve everyone regardless of ability to pay.

PATIENT INFORMATION

Legal Last Name: _____ **Legal First Name:** _____ **MI:**_____

Patient's Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Patient's Physical Address (if different): _____

Date of Birth: _____ **Social Security Number:** _____

COMMUNICATION PREFERENCES

Phone: _____ **Cell Phone:** _____ **Email:** _____

How do you want to be contacted (check all that apply)? [ ] Cell Phone [ ] Email [ ] Text Message

Is it okay for us to leave you a voicemail and/or text message? [ ] Yes, brief [ ] Yes, extended

What is your primary language? _____ **Do you need an interpreter?** [ ] Yes [ ] No

DEMOGRAPHIC INFORMATION

What is your marital status? [ ] Single [ ] Married [ ] Partner [ ] Divorced [ ] Legally Separated [ ] Widowed

What was your sex at birth? [ ] Female [ ] Male

What is your gender identity? [ ] Female [ ] Transgender Female (male-to-female) [ ] Decline to disclose
[ ] Male [ ] Transgender Male (female-to-male) [ ] Other: _____

What is your race? (Check all that apply) [ ] Decline to disclose [ ] American Indian/Alaska Native [ ] Asian
[ ] Black or African American [ ] Native Hawaiian [ ] Pacific Islander [ ] White [ ] Other: _____

What is your ethnicity? [ ] Decline to disclose [ ] Hispanic or Latino [ ] Not Hispanic or Latino

Are you a current student? [ ] Yes (Full-Time) [ ] Yes (Part-Time) [ ] No

Do you use Public Housing? [ ] Yes [ ] No **Are you a Veteran?** [ ] Yes [ ] No

Are you a Seasonal Worker? [ ] Yes [ ] No **Are you Homeless/Houseless?** [ ] Yes [ ] No

PRIMARY CARE PROVIDER (PCP) & PHARMACY

[ ] My PCP is: _____ [ ] I am establishing care today with: _____

[ ] I am interested in finding a PCP at Greater Valley Health Center [ ] I am not interested in a PCP at this time.

Do you have a preferred pharmacy? [ ] Yes [ ] No

Name: _____ City: _____ State: _____

EMERGENCY CONTACT / AUTHORIZATION OF PERSONAL HEALTH INFORMATION

Would you like to allow GVHC staff to speak with anyone other than yourself about your care AND/OR contact them incase of an emergency?

If No, Skip to the next section.

If Yes, include the name of your trusted person(s) in the space below and check their level of access to your Personal Health Information (PHI). This authorization will expire 18 months (1.5 years) from today. You may also revoke this authorization in writing at any time. Once released to another individual, your personal health information is no longer protected under federal law, and may be re-disclosed by the recipient.

Name: _____ [ ] Emergency Contact Only

Relationship to you: _____ [ ] All Medical & Dental Information

Phone Number: _____ [ ] Entire Record, including Behavioral Health Info

[ ] Limited specifically to: _____

Name: _____ [ ] Emergency Contact Only

Relationship to you: _____ [ ] All Medical & Dental Information

Phone Number: _____ [ ] Entire Record, including Behavioral Health Info

[ ] Limited specifically to: _____

Initials: _____

EMPLOYMENT STATUS

[ ] Self Employed [ ] Full-Time [ ] Part-Time [ ] Retired [ ] Unemployed [ ] Other: _____

Employer Name: _____ **Employer Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

INSURANCE INFORMATION & SLIDING FEE SCALE DISCOUNT PROGRAM

[ ] I would like to APPLY for the Sliding Fee Discount Program (please complete separate application).

[ ] I decline to disclose my financial information. I understand GVHC will assume I am above 200% of Federal Poverty Guidelines and I will not receive any discounted services; therefore I will be responsible for all charges incurred.

[ ] I have the following health insurance: _____

RESPONSIBLE PARTY FOR MINORS

Legal Last Name: _____ Legal First Name: _____ MI:_____

Date of Birth: _____ Relationship to Patient: _____ Phone: _____

Social Security Number: _____ Gender: [ ] Female [ ] Male [ ] Other: _____

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

Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

HIPAA & PRIVACY PRACTICES

I understand the HIPAA notice of privacy practices may change periodically and I am entitled to a copy of the revised HIPAA notice of privacy practices upon request. I understand it is my right to refuse to sign this form if I so choose and treatment will not be refused to me if I do not sign. I consent to GVHC use and disclosure of my health information for treatment, payment, and health care operations. I have received a copy of HIPAA notice of privacy practices informing me of how my medical information may be used and disclosed. This document also explains how I can access medical information for myself and my dependents.

INITIAL HERE:_____

NOTICE OF IMMUNIZATION & INFECTIOUS DISEASE REPORTING AND RECORD KEEPING

I have been notified GVHC reports immunization data to the State Registry (imMTrax). I have also been informed GVHC is obligated to report certain cases of infectious disease to my local health department. I understand if I have any concerns I should talk to my provider.

INITIAL HERE:_____

CONSENT TO PATIENT PORTAL

GVHC offers this secure, HIPAA compliant communication tool as a courtesy to patients. It is an optional service which may be terminated or suspended at any time. The web portal or webpage has a secure tunnel connection with the clinic that uses encryption to keep unauthorized persons from being able to access and read health information or communications to providers. To help insure the tunnel remains secure, I agree to provide my current (private) email address and provide updates should it ever change. I agree to keep my portal user ID and password secure so only I, or someone authorized by me, can gain access to patient information. By signing this form I confirm that I agree to comply with our procedures and guidelines for using the Patient Portal and consent to activation of my Patient Portal.

INITIAL HERE:_____

ACKNOWLEDGEMENT OF NO SHOW POLICY

Your providers want to make sure you and other area residents have access to high-quality care when you need it. To ensure maximum access to services for all of our patients, please be aware we have a policy for scheduled appointments, late visits, canceling appointments, and missed appointments.

1. Scheduled Appointments- Although we will make every effort to remind you of your upcoming visit by phone, mail, or email you are ultimately responsible for remembering your appointment and time.

2. Late Visits- Our patient's time is very important to us. So we work hard to stay on schedule and enforce a "Late Policy." Patients who arrive 10 minutes late for their scheduled appointment will be asked to reschedule for a different day.

3. Canceling Appointments- If you cannot make your scheduled appointment please call us at least 24 hours in advance to let us know so we can offer your appointment time to another patient in need. Failure to provide at least 24 hour notice will count as a missed appointment.

4. Missed Appointments- Missed appointments are taken very seriously. Your first two missed scheduled visits will be documented. If you miss a third visit within a rolling 12 month period without proper notice you will be placed on a "no show status." If this happens you will only be able to access care through same day scheduling.

INITIAL HERE:_____

AUTHORIZATION & ASSIGNMENT

MEDICAL HOME RIGHTS AND RESPONSIBILITIES I understand GREATER VALLEY HEALTH CENTER will be my Medical Home. This means that I am entitled to choose my provider, and to receive continuity in care by working together with my chosen provider and their care team. I will inform GVHC and/or my care team of all matters concerning my health. I have received the GREATER VALLEY HEALTH CENTER patient rights and responsibilities. TREATMENT/ PAYMENT AGREEMENT FOR GREATER VALLEY HEATLH CENTER (GVHC) I request GREATER VALLEY HEALTH CENTER provide me and/or my family with medical care. I accept responsibility for any fees for services not covered by my insurance or sliding fee scale. Furthermore, I authorize assignment of benefits for services to be paid to GVHC. Also, I authorize GVHC to bill my insurance and release information to the insurance company if requested. I will communicate to GVHC any changes to my income and/or insurance status. I understand and give consent for my information to be accessed by outside entities for the purposes of auditing the facilities' compliance with federal, state, and pharmaceutical program business rules. The information given on this form is true, correct, and complete. I understand it is in my best interest to report all changes in a timely manner

INITIAL HERE:_____

Patient/ Parent/ Legal Guardian: _____ **Date:** _____