



GREATER VALLEY HEALTH CENTER

Patient Intake Form

Some of this information is gathered for our grant & grant reporting.
No individual information will be shared. The grant helps us to serve everyone regardless of ability to pay.

PATIENT INFORMATION

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

Home Phone: _____ Cell Phone: _____ Date of birth: _____

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

Social Security Number: _____ Email: _____

Do you have hearing impairment? Yes No What is your primary language: English Other: _____

Do you need an interpreter? Yes No

What is your race? (Check all that apply)

American Indian or Alaskan Native White Native Hawaiian Black or African American Asian
 Pacific Islander Decline to disclose Other: _____

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

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Phone Number: _____ Can this person have access to your records? Yes No

Name: _____ Relationship to you: _____

Phone Number: _____ Can this person have access to your records? Yes No

COMMUNICATION PREFERENCES

How do you want to be contacted? Cell Phone Email Text No Preference

Is it okay for us to leave you a voicemail and/or text messages? Yes, Brief Yes, Extended No

RESPONSIBLE PARTY FOR MINORS

First Name: _____ MI: _____ Last Name: _____ Date of Birth: _____

Social Security: _____ Gender: Female Male Other: _____

Relationship to Patient: _____

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

Employer Name: _____

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

EMPLOYMENT STATUS

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

Employer Name: _____

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

Employer Phone: _____

I would like to APPLY for the Sliding Fee Scale Discount Program (Please complete separate application.)

I decline to disclose my financial information and understand I will not receive any discounted services and will be responsible for the charges incurred.

I have health insurance: _____

PRIMARY CARE PROVIDER (PCP)

Yes, my PCP is: _____

I am establishing care today with: _____

No, but I am interested in finding a PCP at Greater Valley Health Center.

No, and I am not interested in finding a PCP at this time.

PREFERRED PHARMACY

Do you have a preferred pharmacy? Yes No

Name: _____ City: _____ State: _____

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

What is your marital status? Single Married Partner Divorced Legally separated Widowed

What was your sex at birth? Female Male Decline to disclose

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

What are your preferred pronouns? She/Her He/Him They /Them Decline to disclose Other: _____

Do you use Public Housing? Yes No

Are you Homeless/Houseless? Yes No

Are you a Seasonal Worker? Yes No

Are you a Veteran? Yes No

AUTHORIZATION OF PERSONAL HEALTH INFORMATION

Would you like to allow GVHC staff to speak with anyone other than yourself about your care?

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.

First Name: _____ Last Name: _____ Phone: _____

Medical & Dental treatment & PHI Appointments & Scheduling Behavioral Health PHI Limited PHI Specifically: _____

First Name: _____ Last Name: _____ Phone: _____

Medical & Dental treatment & PHI Appointments & Scheduling Behavioral Health PHI Limited PHI Specifically: _____

Initial Here: _____

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 HEALTH 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:** _____