Long Valley Health Center

Acct# **Patient Information Sheet and Consent Form**

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Previous Last Name: _____ Sex: ☐ Male ☐ Female

Social Security #: _____ Date of Birth: _____/_____/_____

Mailing Address: _____ City: _____State: _____ Zip Code: _____

Home Address (if different than mailing): _____City: _____State: _____ Zip Code: _____

Please check preferred contact method:

Phone: ☐Home: _____ ☐Work: _____ ☐Cell: _____

(Okay to leave a message? ☐Yes -☐Brief ☐Detailed ☐No)

E-mail address: _____ ☐ No E-mail address

Primary (Preferred) Language**:** ☐English ☐Spanish ☐Other: _____

Marital Status: ☐ Married ☐ Single ☐ Single w/partner ☐ Divorced ☐ Separated ☐ Widow(er)

Employer: _____ Address: _____Work Phone: _____

Pharmacy: _____

Primary Care Provider:

☐Dr. Tom Bertolli ☐Dr. Sharon Paltin ☐Carrie Guilfoyle, ANP-C

☐Other:_____

In case of emergency, please contact:

Name: _____

Phone: _____Relationship:_____

Additional Patient Information (please answer all questions):

By answering the following questions, you will give us information we need to acquire funds to help uninsured and underinsured residents in our community. This information also helps us recognize clients who may qualify for specially funded programs or services.

Sexual orientation and gender identity can play a significant role in determining health outcomes. Asking these questions also improves patient centered care.

Sexual Orientation (Please check one)

☐ Straight/Heterosexual ☐ Gay, Lesbian, Homosexual ☐ Bisexual ☐ Don't Know ☐ Other ☐ Decline to specify

Gender Identification (Please check one)

☐ Female ☐ Male ☐ Female to Male/Transgender ☐ Male to Female/Transgender ☐ Other ☐ Decline to specify

Race (Please check one): ☐ White (including Hispanic / Latino) ☐ Black/African American ☐ Asian

☐ American Indian / Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other:_____ ☐ Decline to specify

Ethnicity (Please check one): ☐ Hispanic or Latino ☐Non-Hispanic ☐ Unreported /Refused to Report

Homeless ☐ YES ☐ NO

If yes, currently living in: ☐ Shelter ☐ Street / Campground ☐ Transitional Housing ☐ Doubling Up (Family or Friend)

Farmworker ☐ YES ☐NO If yes: ☐ Migrant ☐ Seasonal

Current or Discharged Veteran ☐ YES ☐ NO

Family Size: _____Household Income: $_____ ☐ Annual ☐ Monthly

OVER (Please complete other side)

Primary Insurance:

☐ Medi-Cal ☐ Partnership ☐ CMSP ☐ Medicare

☐ Any Other Coverage_____ (Blue Cross, Blue Shield, Delta, etc.)

ID/Subscriber #: _____ Plan/Group #_____

Mailing Address: _____City: _____State: _____ Zip Code: _____

Subscriber Name: _____ Subscriber Date of Birth_____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance:

☐ Medi-Cal ☐ Partnership ☐ CMSP ☐ Medicare

☐ Any Other Coverage: _____ (Blue Cross, Blue Shield, Delta, etc.)

ID/Subscriber #: _____ Plan/Group #_____

Mailing Address: _____City: _____State: _____ Zip Code: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

If patient is a minor, complete this section.

Responsible Party:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to patient: _____ Phone: _____

Address (if different): _____ Date of Birth: _____

City: _____State: _____ Zip Code: _____ Social Security #: _____

Employer: _____ Address: _____ Work Phone: _____

Mother's/Guardian's Name: _____ Date of Birth: _____

Address (if different): _____ Phone: _____

Father's/Guardian's Name: _____ Date of Birth: _____

Address (if different): _____ Phone: _____

1. Release of Information: To the extent necessary to determine the liability for payment and to obtain reimbursement, I authorize Long Valley Health Center to release portions of my medical records to any person, organization, or agency which is or may be liable for all or any portion of LVHC's charges, including but not limited to insurance companies, health service plans, workers' compensation carriers and government agencies. The Dept. of Health Services may audit my medical records for the purpose of Center licensing or for statistical information. Such audits and or release of records will not compromise the confidentiality of my medical record.

2. Financial Agreement: I hereby agree, in consideration of services rendered by Long Valley Health Center, to pay all bills as presented regardless of insurance coverage. I agree, that if it becomes necessary, the account will be referred to a collection agency and I shall pay the collection expenses in full.

3. Consent for Treatment: I, the undersigned, consent to the medical/dental examination, immunizations, treatment and procedures for the care of the above named Patient. I understand that Physician Assistants/Nurse Practitioners (PA/NP) have been approved by the State of CA to dispense drugs and medical supplies on the direct order of a physician or according to previously established written guidelines and that, a physician is always available to the PA/NP for consultation during the assessment and treatment of patients. To assist medical/dental providers to safely prescribe medication and administer immunizations, I consent to their access to the patient's prescription medication history and immunization records.

Signature: _____ Date: _____ Relationship to Patient: _____

Office Use: **_____ *Date:*** **_____ *Title:*** **_____**

Long Valley Health Center
Patient Health Questionnaire

Full Name: _____

Date of Birth: _____

Please take the time to complete this form as best you can. **Today's Date:** _____

This information is important to your provider in determining your overall care.

Have you seen any medical providers or specialists in the past 2 years? ☐ Yes ☐ No

Provider Name(s): _____

Reason: _____

Have you been hospitalized or in the emergency room in the past 2 years? ☐ Yes ☐ No

Reason: _____

PAST MEDICAL HISTORY:

Have you had any of the following health conditions? Please check all that apply.

☐ Hypertension (High blood pressure)	☐ Chronic Pain Location: _____	☐ Hepatitis
☐ High cholesterol	☐ Cancer Type:_____	☐ Liver disease
☐ Coronary artery disease	☐ Enlarged prostrate	☐ Kidney or bladder disease
☐ Atrial fibrillation	☐ Diabetes	☐ Gallbladder disease
☐ Cardiac chest pain	☐ Thyroid disease	☐ Migraine headaches
☐ Heart attack	☐ Hormone imbalance	☐ Eye or visual problems
☐ Stroke	☐ Asthma	☐ Dental problems
☐ Anemia	☐ COPD (emphysema)	☐ Alcohol or Substance Abuse Specify: _____
☐ Bleeding or clotting problems	☐ Tuberculosis	☐ Anxiety
☐ Blood transfusion	☐ Sexually transmitted disease	☐ Depression
☐ Seizures or epilepsy	☐ HIV infection or AIDS	☐ Other Mental Health Concerns Specify:_____
☐ Autoimmune disorder	☐ Stomach ulcers	☐ Memory or cognition problems
☐ Arthritis	☐ Crohn's disease (Inflammatory Bowel Disease)	☐ Other _____
☐ Carpal tunnel syndrome	☐ GERD (Reflux)	☐ Other _____

What is your primary language? _____ **In what country were you born?** _____

Have you travelled outside of the US in the last 5 years? ☐ Yes ☐ No

Where have you travelled? _____

Long Valley Health Center
Patient Health Questionnaire

Full Name: _____

Date of Birth: _____

Please take the time to complete this form as best you can. **Today's Date:** _____

This information is important to your provider in determining your overall care.

CURRENT MEDICATIONS:

List all medications you are currently taking including over the counter medications, herbs, supplements, or vitamins.

_____

_____

_____

ALLERGIES:

If yes, please list below and **describe reaction**.

Are you allergic to any medications? ☐ Yes ☐ No

Any other allergies such as foods, pollens, insects, adhesives, or latex? ☐ Yes ☐ No

_____

IMMUNIZATIONS:

Are your immunizations up-to-date? ☐ Yes ☐ No ☐ Unsure

Have you had a tetanus shot? ☐ Yes ☐ No ☐ Unsure Date: _____

PAST SURGICAL HISTORY:

Have you had any of the following medical procedures?
Please check all that apply and provide the year that the procedure was done.

SURGERY	YEAR	SURGERY	YEAR	SURGERY	YEAR
☐ Angioplasty		☐ Heart bypass surgery		☐ Mastectomy	
Stent? Y/N		☐ Hernia repair		☐ Pacemaker	
☐ Appendectomy		☐ Hip replacement		☐ Prostate Surgery	
☐ Back surgery		☐ Hysterectomy		☐ Thyroidectomy	
☐ Bowel surgery		*Reason:*		☐ Tonsillectomy	
☐ Breast biopsy		*Still have cervix?* Y N		☐ Tubal Ligation	
☐ Caesarean section		*Still have ovaries?* Y N		☐ Vasectomy	
☐ Carpal tunnel release		☐ Knee surgery		☐ Other	
☐ Cataract extraction		☐ LASIK surgery		☐ Other	
☐ Gallbladder surgery		☐ Liver biopsy			
☐ Gastric bypass				☐ None	

HEALTH SCREENINGS:

Have you had a pap smear? ☐ Yes ☐ No Date of most recent pap: _____

If the pap smear was not done at LVHC, please provide doctor's name: _____

Have you had a mammogram? ☐ Yes ☐ No Date of most recent mammogram: _____

Have you had a colonoscopy or other colon cancer screening? ☐ Yes ☐ No Date: _____

Long Valley Health Center
Patient Health Questionnaire

Full Name: _____

Date of Birth: _____

Please take the time to complete this form as best you can. **Today's Date:** _____

This information is important to your provider in determining your overall care.

FAMILY HISTORY:

Have any of your close relatives suffered from chronic or fatal illnesses? Please check all that apply. Please tell us how old they were when the illness began and if fatal, how old they were when they died.

Please check here if you were adopted: ☐

ILLNESS	FATHER	AGE	MOTHER	AGE	SIBLING	AGE	OTHER FAMILY (*please specify*)	AGE
ALIVE & WELL	☐		☐		☐		☐	
Diabetes	☐		☐		☐		☐	
High blood pressure	☐		☐		☐		☐	
High cholesterol	☐		☐		☐		☐	
Heart disease	☐		☐		☐		☐	
Stroke	☐		☐		☐		☐	
Cancer Type:	☐		☐		☐		☐	
Asthma	☐		☐		☐		☐	
Arthritis	☐		☐		☐		☐	
Osteoporosis	☐		☐		☐		☐	
Autoimmune disorder	☐		☐		☐		☐	
Obesity	☐		☐		☐		☐	
Kidney disease	☐		☐		☐		☐	
Blood disease	☐		☐		☐		☐	
Alzheimer's disease	☐		☐		☐		☐	
Depression	☐		☐		☐		☐	
Mental illness	☐		☐		☐		☐	
Alcohol or Substance Abuse	☐		☐		☐		☐	
Hearing loss	☐		☐		☐		☐	
Vision loss	☐		☐		☐		☐	
Other:	☐		☐		☐		☐	

Are You Hearing Impaired? ☐ Y ☐ N Are You Vision Impaired? ☐ Y ☐ N

If yes, please describe: _____

Do you have a caregiver? ☐ Yes ☐ No

Do you need help with self-care needs? ☐ Yes ☐ No

Do you need help with reading or completing forms? ☐ Yes ☐ No

Have you completed any kind of advance directive like a living will, Durable Power of Attorney for Health Care or a POLST form? ☐ Yes ☐ No

Long Valley Health Center
Patient Health Questionnaire

Full Name: _____

Date of Birth: _____

Please take the time to complete this form as best you can. **Today's Date:** _____

This information is important to your provider in determining your overall care.

TOBACCO, DRUG AND ALCOHOL USAGE:

Do you smoke tobacco products? ☐ Current ☐ Past ☐ No
Do you chew tobacco? ☐ Current ☐ Past ☐ No
Do you smoke marijuana? ☐ Current ☐ Past ☐ No
Do you vape? ☐ Current ☐ Past ☐ No
Are you exposed to secondhand smoke? ☐ Yes ☐ No

Do you currently use any recreational drugs? ☐ Yes ☐ No
If yes, please describe: _____

How often do you have a drink containing alcohol? _____
How often do you have a drink containing caffeine? _____

SOCIAL HEALTH:

Do you currently have housing? ☐ Yes ☐ No ☐ Temporary
How many people live in your household? _____

Do you have problems with your housing such as mold, inadequate heat or cooling? ☐ Yes ☐ No
If yes, please describe: _____
In the past year, has electric, gas, water or phone services been shut off in your home? ☐ Yes ☐ No

Do you have difficulty paying for medical care, prescriptions or insurance? ☐ Yes ☐ No
Do you have difficulty with access to transportation? ☐ Yes ☐ No
Do you have difficulty paying for or getting enough quality food? ☐ Yes ☐ No

Do you feel safe in your home? ☐ Yes ☐ No
Do you feel safe in your relationships? ☐ Yes ☐ No

Would you like to speak to someone about these or other concerns? ☐ Yes ☐ No

PATIENT UPDATE: In the last 2 years, have you had any medical, health or social changes?

If yes, please describe: _____

_____

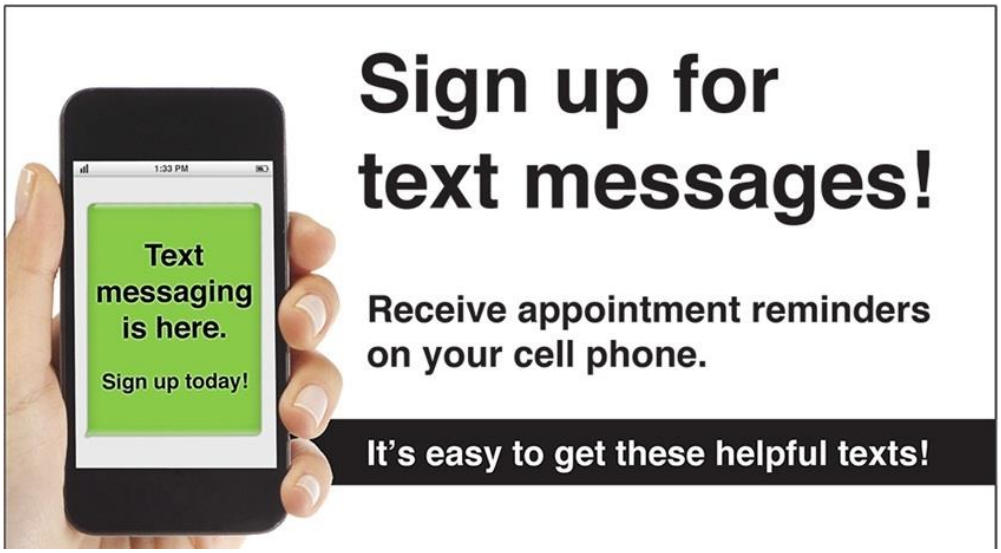
_____

_____

Please sign and date. Thank you for completing this important form about your health.

Signature: _____ **Date:** _____

Long Valley Health Center



Consent to Receive Text Messages

By signing below, I authorize Long Valley Health Center to contact me by SMS text message for appointment reminders and health related notifications.

I understand that message/data rates may apply to messages sent by Long Valley Health Center under my cell phone plan. I will keep Long Valley Health Center informed of my up-to-date cell phone number.

I know that I am under no obligation to authorize Long Valley Health Center to send me text messages. I may opt-out of receiving these communications at any time by calling 707-984-6131 and speaking with a Patient Service representative.

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts and that I agree to all terms and conditions of use for the text messaging services.

☐ Yes, sign me up for SMS text messages!

Name: _____ DOB: _____

Preferred Cell Phone #: _____

Preferred Language: English Spanish

Signature: _____ Date: _____

Long Valley Health Center, 50 Branscomb Road, Laytonville, CA 94954
Phone: 707-984-6131 • Health Information Fax: 707-984-6990
www.longvalley.org

LONG VALLEY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

Effective 4/15/03

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Account Number: _____

Patient Name: _____

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for the above patient.

_____
Signature

_____
Relationship to patient

Date _____

LONG VALLEY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

Effective 4/15/03

This notice describes how health information about you may be used and disclosed and how you can access this information. Please review this notice carefully. For more information, please contact:

Privacy Officer/Health Information Supervisor
Long Valley Health Center
Post Office Box 870
Laytonville, CA 95454
Phone: 707-984-6131 FAX: 707-984-6990
Website: www.longvalley.org

This notice describes the privacy practices of Long Valley Health Center including the practices of:

- all of our doctors, dentists, mid-levels, nurses and other health care professionals authorized to enter information about you into your health record.
- all of our departments including Health Information and Billing.
- all of our employees, staff, volunteers and other personnel who work for us or on our behalf.

We understand that health information about you and the health care you receive is personal. When you receive treatment and other services from us, a record is created. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office.

This notice informs you of the ways in which we may use and disclose your personal health information. It also describes your rights with respect to the health information we keep about you as well as the obligations we must meet when we use and disclose your health information. It includes information on how you may file a complaint if you believe your privacy rights have been violated.

We are committed to protecting your personal health information. In compliance with the law, the attached Notice of Privacy Practices states:

- that we will make sure that health information that identifies you is kept private in accordance with relevant law.
- that we have the right to make changes in our privacy practices and this notice provided the changes are permitted by law.
- that we will give you this notice of our legal duties and privacy practices with respect to your personal health information.
- that we will follow the terms of the policy that is currently in effect for all of your personal health information.

LONG VALLEY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

Effective 4/15/03

We may use and disclose your personal health information for the following:

For Treatment: We may use health information about you to provide necessary treatment or services. We may disclose health information about you to the health care providers, technicians, and others who are involved in your care. They may work at Long Valley Health Center or at another doctor's office, hospital, lab, or pharmacy to whom we refer you for treatment, consultation, X-Rays, lab tests, prescriptions or other health care services. For example, we may disclose to an emergency room doctor that you are allergic to penicillin, as this may effect medication choices.

For Payment: We may use and disclose health information about you to bill and collect payment from you, your insurance company, including Medi-Cal and Medicare, or other third party. For example, if you have insurance, we may need to share information about your office visit with your health plan in order for your health plan to pay us or reimburse you for the visit. We may also tell your health plan about treatment you need in order to obtain their prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for our day-to-day operations. These uses and disclosures are necessary to run Long Valley Health Center and to make sure that all of our patients receive quality care. For example, we may use health information to review the services we provide and to evaluate the performance of our staff in caring for you. We may also combine health information about our patients with health information from other health care providers to decide what additional services we should offer, what services are not needed, whether new treatments are effective or to compare how we are doing with others and to see where we can make improvements. We will remove identifying information from this so it may be used to study health care delivery without identifying our patients.

Appointment Reminders: We may use health information about you to contact you as a reminder that you have an appointment at the Health Center.

Health-related services and treatment alternatives: We may use and disclose health information to inform you of health-related services or recommend treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to contact you with this information, or if you wish to have us use a different address.

Research: Under certain circumstances, we may use and disclose health information about you for research purposes. All research projects are subject to a special approval board that has reviewed the research proposal and established protocols to ensure the privacy of the health information.

Organ and Tissue Donation: If you are an organ donor, we may disclose health information about you to organizations that handle procurement, transplantation or donation as necessary to facilitate organ or tissue donation and transplantation.

Military and veterans: If you are a member of the armed forces or separated/discharged from military service, we may release health information as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release health information as required by law for workers' compensation or similar programs.

LONG VALLEY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

Effective 4/15/03

As Required by Law: We may disclose health information about you to law enforcement and other government agencies to support government audits and inspections, to facilitate investigations and to comply with government-mandated reporting when required to do so by federal, state or local law.

Public Health Activities: We may disclose health information about you to Public Health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Lawsuits and Disputes: We may disclose health information in response to a court or administrative order, in response to a subpoena, discovery request or other lawful process not accompanied by a court or administrative order but only after efforts have been made to inform you of the request or to obtain an order protecting the information requested.

Coroners/Health Examiners: We may release health information to a coroner/health examiner as required by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law, i.e., audits, investigations, inspections and licensure necessary for the government to monitor health care programs and compliance with civil rights laws.

Inmates: If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release health information about you to the correctional institution or law enforcement official as required by law.

LONG VALLEY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

Effective 4/15/03

Your Rights: You have certain rights with respect to your personal health information. This section describes your rights and how to exercise them:

Right to Inspect and Copy: You may inspect and/or receive a copy of your personal health information as permitted by state and federal law. This does not include psychotherapy notes, although we may, at your request and upon payment of the applicable fee, provide you with a summary of these notes.

To view or inspect your personal health information, you must make an appointment for this purpose with your primary provider. To receive a copy of your personal health information, you must submit your request in writing to our Privacy Officer. We may charge a fee for the copying, mailing and any other costs associated with your request. Our policy is to only release information produced by Health Center staff. With only certain exceptions (i.e., X-Ray or lab reports), requests for information produced by other providers/agencies involved in your health care must be requested from that agency.

In very limited circumstances, we may deny your request to inspect and/or receive a copy of your personal health information. If denied, you may request the denial be reviewed. We will designate a licensed health care professional to review this denial. The person conducting the review will not be the same person who denied your request. We will comply with the outcome of this review. Certain denials such as those relating to psychotherapy notes will not be reviewed.

Right to Amend: If you feel that the health information we maintain about you is incorrect or incomplete, you may request an amendment of this information. To request an amendment your request must be made in writing and submitted to our Privacy Officer. This must be contained on one piece of paper legibly written or typed. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- ❑ was not created by us, unless the person or organization that created the information is no longer available to make the amendment.
- ❑ is not part of the health information kept by or for the Health Center
- ❑ is not part of information you would be permitted to inspect and copy.
- ❑ is to our knowledge accurate and complete.

List of Disclosures: To request an accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period of not more than six (6) years and may not include dates before 04/15/03. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost and you may choose to withdraw or modify your request before costs are incurred. We will mail you a list of disclosures within thirty (30) days or notify you if we are unable to supply the list within that time period and by what date we can supply the list. This date will not exceed sixty (60) days from the date you made the request.

Right to Request Restrictions: You may request a restriction/limitation on the health information we use or disclose about you for treatment, payment or health care operations. You may request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.
We may deny your request for restrictions, if it is not feasible for us to comply with your request or if we believe that it will negatively impact our ability to care for you. If we do agree, however, we will comply with your request unless the information is needed to provide emergency treatment or disclosure is required by law. To request a restriction, you must make your request

in writing to our Privacy Officer. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Receive Confidential Communications: You may request that we communicate with you about health matters in a certain way, such as only contacting you at work or by mail at a specified address. You must make your request in writing to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to receive another copy of this notice at any time. To receive a copy, please request it from our Privacy Officer. You may also obtain a copy of this notice at our website at: www.longvalley.org .

Changes to this notice: In order to comply with changes in state and federal law, we may have to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you, or information we may receive about you in the future. We will post a copy of our current notice in our facility. Our notice will indicate the effective date on the top right-hand corner of each page. We will also give you a copy of our current notice upon request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You may file a complaint by mailing, faxing or E-mailing us a written description of your complaint or by telling us about your complaint in person or over the telephone. Please describe what happened and give us the dates and names of everyone involved. Please also give us contact information, so we may respond to your complaint. You will not be penalized for filing a complaint. Please address your complaints to:

Privacy Officer/Health Information Supervisor
Long Valley Health Center
Post Office Box 870
Laytonville, California 95454
Phone - 707-984-6131 Fax - 707-984-6990
Website: www.longvalley.org

Other Uses and Disclosures of Your Protected Health Information:

Other uses and disclosures of personal health information not covered by this notice or applicable law will be made only with your written authorization. If you give us your written authorization to use or disclose your personal health information, you may revoke your authorization, in writing at any time. If you revoke your authorization, we will no longer use or disclose your personal health information for the reasons covered in your written authorization. You understand we are unable to take back any uses and/or disclosures that have already been made with your authorization and we are required to retain our records of the care that we have provided to you.