CommuniCare+OLE

Caring for Napa, Solano & Yolo Counties

Place Patient Label Here

PATIENT REGISTRATION AND CONSENT

Preferred/Chosen Name	Primary Language	**Do you need translation services?** ☐ Yes ☐ No	
Legal Last Name	Legal First Name	MI	Date of Birth
Mailing Address	City	State	Zip Code
Street Address	City	State	Zip Code
Home Phone	Cell Phone	**Ok to send text messages?** ☐ Yes ☐ No	

What sex were you assigned at birth? (check one)

☐ Female ☐ Male ☐ Unknown ☐ Decline to State
☐ Intersex – No record of Birth Certificate

What pronoun do you use? (check one)

☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Decline to State
☐ Additional category (please specify): _____

What is your sexual orientation? (check all that apply)

☐ Straight/Heterosexual ☐ Queer ☐ Don't Know
☐ Lesbian/Gay ☐ Bisexual ☐ Decline to State
☐ Asexual ☐ Omnisexual ☐ Pansexual
☐ Something Else

What is your current gender identity? (check all that apply)

☐ Male ☐ Transgender Male/Transman/FTM ☐ Non-binary-genderqueer
☐ Female ☐Transgender Female/Transwoman/MTF ☐ Questioning
☐ Two Spirit ☐ Decline to State ☐ Other _____

Marital Status (check one):

☐ Divorced ☐ Unknown
☐ Married ☐ Widowed
☐ Other ☐ Single
☐ Domestic Partner
☐ Legally Separated
☐ Significant Other

Emergency Contact (Please print "none" below if you do not have an emergency contact)

Last Name	First Name
Relationship to Patient	Phone Number

Insurance Type (check one):

☐ Medi-Cal/Partnership ☐ Private Insurance ☐ Covered California ☐ Medicare ☐ None
☐Other (please specify) _____

Social Security Number	Email Address	Preferred Pharmacy

For patients under 18, Parent or Legal Guardian Information:

Last Name	First Name	Date of Birth	Phone Number

Additional Patient Information (Please answer ALL questions)

CommuniCare+OLE is a non-profit. By answering these questions, you will give us information needed to acquire grant funds that help uninsured and underinsured people in our community. Please help us serve you and our community by providing us with this information. This information will become a part of your confidential medical record.

Do you consider yourself to be Hispanic/Latino/a/x?

☐ Yes, Mexican ☐ Yes, Cuban
☐ Yes, Mexican American ☐ Yes, Chicano/a/x
☐ Yes, Mexican American Indian ☐ Yes, Puerto Rican
☐ Yes, other Hispanic, Latino/a/x or Spanish origin
☐ No
☐ Decline to State

Race/Ethnicity (check all that apply):

☐ Asian Indian ☐ Native Hawaiian ☐ White
☐ Chinese ☐ Other Pacific Islander ☐ Filipino
☐ Guamanian or Chamorro ☐ Japanese ☐ Samoan
☐ Korean ☐ Black/African American ☐ Vietnamese
☐ American Indian/Alaska Native ☐ Other Asian: _____
☐ Other: _____ ☐ Decline to State

Are you disabled?

☐ Yes ☐ No

Are you a Veteran?

☐ Yes ☐ No

Are you a seasonal/migrant agricultural worker? (check all that apply):

☐ Migrant Agricultural worker: my main job is agriculture and I move to find my jobs
☐ Seasonal agricultural worker: My main job is agriculture, and I don't work year round

Where are you currently living? (check all that apply)

☐ Home/Apartment ☐ Outside (Street/Car) ☐ Shelter
☐ Staying with Friends/Family ☐ Transitional House
☐ Other: _____

How many people are in your household?

How much income did everyone in your house get last month before taxes?

PLEASE TURN OVER AND CONTINUE ON THE BACK

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CONSENTS

To provide treatment, bill your insurance, or release information required by your insurance carrier, etc., we must receive your consent by initialing the areas indicated and by providing your signature below.

Assignment of Benefits: I assign to CommuniCare+OLE (CCOLE) all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by CCOLE. _____ **(initials)**

Consent of Treatment: I authorize CCOLE and its medical, nursing, and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of CCOLE's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by CCOLE personnel. _____ **(initials)**

Consent to Telehealth: Beneficiaries have the right to access covered services via telehealth, which involves the use of audio, video, or other electronic communications to interact with patients, consult with healthcare providers and/or review medical information for the purpose of diagnosis, therapy, follow-up and/or education. During a telehealth visit, details of my medical history and personal health information may be discussed with other health professionals using interactive video, audio, and telecommunications technology. Additionally, a physical examination may take place and video, audio, and/or photo recordings may be taken. The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. I understand that telehealth visits are voluntary, and my consent can be withdrawn at any time. I acknowledge there may be limitations or risks related to receiving services through telehealth as compared to an in-person visit including, but not limited to, potential connectivity issues, a restricted ability to perform a comprehensive physical examination or deliver immediate intervention, etc. I authorize CCOLE and its medical, nursing, and other professional staff members, to provide telehealth care services if it is advisable in my care. _____ **(initials)**

Transportation Assistance: I understand that transportation for Medi-Cal beneficiaries is available for in-person visits if I am having trouble traveling to and from my appointments. _____ **(initials)**

Patient Acknowledgement: I acknowledge receiving notice that under federal law relating to the operation of health centers, the Federal Tort Claims Act (FTCA) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions within the scope of any clinic volunteer or employee health practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. (See Public Health Service Act subsection 224(q), codified at 42 U.S.C. § 233(q) This acknowledgment of notification of the limitation on liability is being provided before health care services have been provided to me by this individual. _____ **(initials)**

Patient Consent for E-prescribing and Web Portal Invite: I agree that CCOLE may e-prescribe my prescriptions and may request and use my prescription medication history from their healthcare providers or third-party pharmacy benefit payers for treatment purposes. Additionally, if I provided an email address, I understand CCOLE will send me an invitation to join the web portal and I have received a copy of the Patient Portal User Agreement. _____ **(initials)**

No Show Policy: A "no-show" refers to a patient who misses an appointment without cancelling/re-scheduling with at least 24-hour notice by phone, portal, text, or in-person. To accommodate the significant number of individuals waiting for appointments, I acknowledge that if I "no show" to three (3) appointments in a 6-month period, I may not be allowed to make scheduled appointments and may have to come in on a walk-in only basis for a six-month period. _____ **(initials)**

Open Payments Database: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. I acknowledge that CCOLE has notified me about the Open Payments Database. _____ **(initials)**

Taking of pictures and/or recording of video/audio: I consent to clinic photo, audio, or video recording by CCOLE and its medical, nursing, and other professional staff members. I understand that the purposes of these photos are for identification, documentation processes of diagnosis and/or treatment. I acknowledge that these photo/audio/video recordings are used for the provision of care, quality improvement, education, and/or reimbursement purposes. _____ **(initials)**

Late Policy: I acknowledge that if I am more than 5 minutes late for my appointment, I may need to wait, to be seen at the next available opening. Please note: While every effort will be made to see you, we cannot guarantee an appointment will be available. You are more than welcome to reschedule your appointment if you are unable to wait. _____ **(initials)**

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CONSENTS CONTINUED

Authorization for Release of Medical Information: Some patients prefer that certain individuals, including family members, be allowed access to their medical information. The individuals I opt to identify below have my permission to make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of my diagnosis, prognosis, and treatment plans, billing information, and serve as an emergency contact. I can let CCOLE know at any point if I want to change or limit this permission. This permission applies to telephone and answering machine messages as well as other means of communication. For more detailed information about how health information is shared with others, please see the CCOLE Notice of Privacy Practices. _____ **(initials)**

OCHIN HIE Consent

CommuniCare+OLE is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org as a business associate of CommuniCare+OLE. OCHIN supplies information technology and related services to CommuniCare+OLE and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by CommuniCare+OLE with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

Please Indicate name and relationship of person(s) you would like to grant access to below. (Additional names can be added to the back of this form if necessary.)

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

These consents will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not influence any actions taken prior to receiving the revocation.

Patient Signature: _____ Date: _____

Legal Guardian (if applicable) Print Name: _____

Signature: _____ Date: _____

Telephone: _____ Relationship: _____

Patient Rights and Responsibilities

As one of our clients, you have choices, rights, and responsibilities:

YOU HAVE THE RIGHT TO…

Be treated with dignity and respect. Maintain your privacy and confidentiality.
Receive explanations about any tests or clinic procedures and any questions you may have. Receive education and counseling.
Review your medical record with a doctor or practitioner. Consent to or refuse any care or treatment.
Participate in making plans or decisions about your care.

YOU ALSO HAVE THE RESPONSIBILITY TO…

To be honest about your medical history and lifestyle which may affect your health. Be sure you understand.
Follow health advice and instructions. Respect Health Center policies.
Report any changes in your health.
Keep appointments or cancel them at least 24 hours in advance.