Chart # _____ / EE Initials _____

PATIENT REGISTRATION

Patient Information (Please print clearly) Name must match what is on your insurance card(s) or we may not be able to bill.

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

Preferred Name: _____ **Birthdate**: _____ **Sex at Birth**: ❑F ❑M **SSN** _____

Marital Status: ❑S ❑M ❑D ❑W ❑SEP **Email Address**: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Physical Address (if different): _____ City: _____ ST: _____ Zip: _____

Cell Phone #: _____ **Can we contact you via text?** ❑Yes ❑No **Leave Voice Message?:** ❑Yes ❑No

Alternate Phone # (if applicable): _____ ❑Home Landline ❑Work ❑Message Phone

Emergency Contact: _____ **Phone:** _____

Relationship: _____ **Does this person know that you are a patient at Hill Country?** ❑Yes ❑No

Parent or Legal Guardian(s) - *(if patient is minor)*

Is there a legal custody agreement in place for this minor? ❑Yes ❑No *(if yes, please provide a copy for our records)*

Parent/Guardian Name:		Parent/Guardian Name:	
Date of Birth:		Date of Birth:	
Relationship to Minor:		Relationship to Minor:	
Address:		Address:	
Phone number:		Phone number:	

Patient Demographics: ***WHY DOES HILL COUNTRY ASK FOR THIS INFORMATION?*** To enable us to qualify for our grants and meet our Federal and State reporting requirements, along with possibly allowing us to offer more services, we must ask for the following information. Your answers are strictly confidential. Your name will not be used. Please check the appropriate box.

Language at home:	❑English ❑Spanish ❑Other: _____
Race: (Check all that apply)	❑White ❑Black/African American ❑Native Hawaiian ❑Other Pacific Islander ❑Asian Indian ❑Chinese ❑American Indian/Alaskan Native ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Other Asian ❑Samoan ❑Guamanian or Chamorro ❑More than one race ❑Choose not to disclose race
Ethnicity:	❑Not Hispanic, Latino/a or Spanish Origin ❑Puerto Rican ❑Mexican, Mexican American, Chicano/ ❑Another Hispanic, Latino/a, or Spanish Origin ❑Cuban ❑ Choose not to disclose ethnicity
Sexual Orientation:	❑ Lesbian or Gay ❑Heterosexual (straight) ❑Bisexual ❑Don't Know ❑Choose not to disclose ❑Other
Gender Identity:	❑ Male ❑Female ❑Choose Not To Disclose ❑Transgender Man/Transgender Male/Transmasculine ❑Transgender Woman/Transgender Female/Transfeminine ❑Other

Are you a Veteran?: ❑Yes ❑No	**Agricultural (Farm) Worker?:** ❑Yes ❑No **If yes, are you:** ❑Seasonal ❑Migrant
Homeless: ❑No ❑**Yes** →	**IF HOMELESS, currently living in:** ❑Homeless shelter ❑Transitional Housing ❑Doubled Up ❑Street ❑Permanent supportive housing ❑Other

Family Size: _____ **What is your Average Monthly Income:** _____ **❑Declined to provide information**

The preceding information is true to the best of my knowledge:

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Chart # _____ / EE Initials _____

PATIENT CONSENTS

Consent for Medical/Dental/Behavioral Health Treatment

Patient Name:_____ **Date of Birth:** _____

ADULT: I hereby authorize Hill Country Community Clinic and all persons acting as agents thereof, as well as all medical/dental/therapeutic personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic, medical / dental / behavioral health treatment to me whether services are in-person or via telehealth (phone or video).

If MINOR: I, as the parent/guardian (circle one) of the above named minor, hereby authorize Hill Country Community Clinic medical/dental personnel/therapeutic to whom said minor is referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic, medical / dental / behavioral health treatment to said minor whether services are in-person or via telehealth (phone or video). This consent shall remain in force until a written revocation is filed at the clinic.

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law.

Our Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to provide you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this Notice.

Patient Acknowledgement of Receipt/Opt Out

☐ **I have been provided a copy of the health center's Notice of Privacy Practices**

☐ **I have been offered, but have chosen not to receive copy of the health center's Notice of Privacy Practices**

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Chart # _____ / EE Initials _____

FINANCIAL AGREEMENT / MEDICAL & DENTAL INSURANCE POLICIES

Primary MEDICAL Insurance / ❑ NONE

ID#: _____ **Group #:** _____	❑Medicare ❑AARP Medicare Advantage Secure Horizons PPO (HMO plan *NOT* accepted) ❑Partnership / Medi-Cal ❑Anthem Blue Cross ❑Blue Shield ❑Aetna ❑Cigna ❑United Healthcare ❑Tri-West/Tricare ❑OTHER: _____

Is the Patient the Primary Insured / Policyholder: **YES / NO**

IF NO, please provide the following information about the primary policy holder:

Relationship to patient (circle one): SPOUSE / PARENT

Name:_____ DOB: _____ SSN: _____ Sex: ❑F ❑M

Secondary MEDICAL Insurance / ❑ NONE

ID#: _____ **Group #:** _____	❑Medicare ❑AARP Medicare Advantage Secure Horizons PPO (HMO plan *NOT* accepted) ❑Partnership / Medi-Cal ❑Anthem Blue Cross ❑Blue Shield ❑Aetna ❑Cigna ❑United Healthcare ❑Tri-West/Tricare ❑OTHER: _____

Is the Patient the Primary Insured / Policyholder: **YES / NO**

IF NO, please provide the following information about the primary policy holder:

Relationship to patient (circle one): SPOUSE / PARENT

Name:_____ DOB: _____ SSN: _____ Sex: ❑F ❑M

DENTAL Insurance / ❑ NONE

ID#: _____ **Group #:** _____	❑ Partnership / Medi-Cal ❑Delta ❑Humana ❑Anthem Blue Cross ❑Cypress Care ❑Blue Shield ❑OTHER: _____

Is the Patient the Primary Insured / Policyholder: **YES / NO**

IF NO, please provide the following information about the primary policy holder:

Relationship to patient (circle one): SPOUSE / PARENT

Name:_____ DOB: _____ SSN: _____ Sex: ❑F ❑M

PLEASE PROVIDE YOUR PRESCRIPTION COVERAGE CARD IF DIFFERENT FROM THE INFORMATION PROVIDED ABOVE

Chart # _____ / EE Initials _____

Payment and Billing Policy

You are responsible for all charges incurred on your account. Payment is expected at time of service for fees that have been determined to be the responsibility of the patient.

- **Medi-Cal/CMSP/Partnership:** Hill Country accepts Medi-Cal, CMSP, and Partnership. A current card must be presented at each visit.
- **Medicare:** We are required to collect additional information to determine coverage.
- **Insurance Plan:** We are contracted with many but not all insurance carriers. If we don't appear on your insurance carriers provider list this may affect how your insurance plan pays for your care and you may be required to pay at time of service.
- **Payment Methods:** Hill Country Community Clinic accepts cash, personal checks, debit cards, Visa and MasterCard. A $10.00 service fee will be charged for bounced checks.

A sliding fee discount is available for qualifying patients who are unable to afford care

- I hereby authorize the release of any and all information acquired in the course of my examination/treatment as required by my insurance carrier.
- I hereby authorize and request the payment of benefits be sent directly to Hill Country Community Clinic for services rendered.
- These assignments will remain in effect until revoked by me in writing. A copy of this agreement is considered as valid as the original.

I have read the above Patient Financial Agreement and agree by signing below:

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Medicare Beneficiary Screening

Please answer the following questions ONLY if you have Medicare Insurance

As a direct result of mandated Medicare Secondary Payer (MSP) Regulations, HCCC is required to gather information to determine if Medicare is your primary insurance.

1. Is this visit due to an automobile accident, liability accident or Workman's Compensation? ☐**Yes** ☐**No**

2. Is this visit covered by the Black Lung Program, Veterans Administration program or a Government Research Program? ☐**Yes** ☐**No**

3. Under 65 and an end stage renal patient in your first 36 months of Medicare entitlement? ☐**Yes** ☐**No**

4. If under age 65, is your Medicare coverage due to disability? ☐**Yes** ☐**No**

5. Are you covered by a health plan through your employer or spouse's employer? ☐**Yes** ☐**No**

=

Office use only:

A. If patient responds "no" to questions 1-5, Medicare is primary.

B. If patient responds "yes" to any questions 1-5 and there is a second insurance (other than "Medicare Supplemental plan, Part D or Medi-Cal), Medicare is secondary and primary insurance information must be obtained.

Chart # _____ / EE Initials _____

SLIDING FEE DISCOUNT PROGRAM

You may qualify for a discount on services provided by Hill Country Community Clinic even if you have insurance, Medicare, or Medi-CAL. To Apply – Please provide the requested information below, sign and date.

Please list yourself and any other person(s) living in your household that you are financially responsible for **and** the total income (before taxes) for each person (do not include food stamps or other non-cash income). ***This information helps Hill Country continue to provide grant funded services to our patients.***

ID# (Office Use)	Full Name	Date of Birth	Monthly Gross Income

☐ **I am not eligible for this program. My household income exceeds 200% of poverty level (please see back of form for reference).**

☐ **I Decline. I prefer not to participate in this program. I understand that services not covered by my insurance may be billed to me without discount.**

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

If you are eligible, the discount will be valid for one year from the effective date.

See our handout **Sliding Fee Discounts at HCCC** for program details.

Office Use Only ☐ Refused / Declined (must have signature above)

Household size: _____ Total Monthly Income: _____

Discount Level: A B C D E (not eligible/over income) _____% FPG

Reviewed by (date/initial): _____&_____ Scanned: _____

Application Effective Date: _____ Renewal Date: _____

Chart # _____ / EE Initials _____

Unsure if you exceed 200% of poverty?

Please review the tiers below. If your income is higher than the income example furthest to the right, you may not qualify. If you have questions, please ask our front office staff. Thank you.

Monthly Income

Level D 171 - 200%			
Family Size	Family Income		
1	2,218	to	2,608
2	2,997	to	3,525
3	3,776	to	4,442
4	4,556	to	5,358
5	5,335	to	6,275
6	6,114	to	7,192
7	6,893	to	8,108
8	7,672	to	9,025
9	8,451	to	9,942
10	9,231	to	10,858
11	10,010	to	11,775
12	10,789	to	12,692

Dental - $60
Counseling - $25
Medical - $40

917 <Per Family Member Increment

Annual Income

Level D 171 - 200%			
Family Size	Family Income		
1	26,606	to	31,300
2	35,956	to	42,300
3	45,306	to	53,300
4	54,656	to	64,300
5	64,006	to	75,300
6	73,356	to	86,300
7	82,706	to	97,300
8	92,056	to	108,300
9	101,406	to	119,300
10	110,756	to	130,300
11	120,106	to	141,300
12	129,456	to	152,300

Dental - $60
Counseling - $25
Medical - $40

11,000 <Per Family Member Increment

Chart # _____ / EE Initials _____

Hill Country No Show Policy

As of June 1, 2023

What is a "No Show"?

A patient is a "no-show" if they miss their appointment AND do not let the clinic know at least two hours before.

Medical

Patients who “no show” two medical appointments in six months can only get care by on a walk-in basis in for six months.

Dental

Patients who “no show” two dental appointments in six months can only get care by on a walk-in basis in for six months.

Behavioral Health

Patients who “no-show” three behavioral health appointments in a row will need to call to be put back on the waitlist.

What does 'Walk-In Basis' Mean?

In Medical and Dental, patients will get suggested times to come to the clinic in case another patient doesn’t show up. There’s no guarantee you’ll be seen that day, and you might need to come back on other days.

What Happens Next?

For Medical and Dental, patients will remain on “walk-in basis” for six months but must have at least one completed visit before they can schedule appointments. For behavioral health, patients must wait on the list until it is their turn and a provider has an opening.

Questions?

Call 530-337-5757

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Chart # _____ / EE Initials _____

Shared Health Information Consent

Hill Country's Electronic Health Record (EHR) system helps your care team share important health information. This means your medical, dental, and behavioral health providers can see key details about your care.

We also participate in SacValley Med Share, a Health Information Exchange (HIE). This allows hospitals and emergency rooms to securely access your records in emergencies or after hours. New patients are **automatically enrolled** in SacValley MedShare.

For more information, visit sacvalleyms.org.

Shared Health Information:

Hill Country Providers Only:

- Health symptoms and diagnoses (past or present)
- Treatment goals and plans
- Medications
- Test and lab results
- Referrals and specialty care

SacValley MedShare (HIE):

- Allergies
- Immunizations
- Lab results

How to Opt-Out of SacValley MedShare:

If you do **not** want to participate, submit the opt-out form here:

English: https://sacvalleyms.org/wp-content/uploads/2024/06/SVMS-FORM-002-006-Opt-OutForm.pdf

Spanish: https://sacvalleyms.org/wp-content/uploads/2024/06/SVMS-FORM-002-006-Opt-OutForm-Spanish.pdf

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Chart # _____ / EE Initials _____

ADDITIONAL CONSENTS OR DISCLOSURES

Patient Consent for the Release of Information on Voicemail or Answering Machine

I, _____ , give my permission for the following normal result information: lab results, pap test results, pathology reports, x-ray results, and referrals, prescriptions, and appointment information to be left on the voicemail/answering machine of any phone numbers I provide to Hill Country Community Clinic to contact me.

I understand I also have the option to review or request some of this information via the Patient Portal.

This authorization is effective until rescinded by myself in writing.

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

IF PATIENT IS A MINOR (optional):

Permission for a Non-Parent/Guardian Adult to Bring Minor for Care (Parental Delegation)

I, _____ _____ of
Name of Parent or Legal Guardian — Relationship to Minor

_____ _____ give authorization for:
Minor Patient Name — Minor's Date of Birth

_____ _____
Print Name — Relationship to Parent/Guardian

_____ _____
Print Name — Relationship to Parent/Guardian

_____ _____
Print Name — Relationship to Parent/Guardian

to bring Minor to **Hill Country Community Clinic** for medical, behavioral health, and/or dental treatment in the event that I am unavailable to do so. **This authorization is effective until rescinded by myself in writing.**

PARENT / LEGAL GUARDIAN SIGNATURE:	►	**DATE:**

Chart # _____ / EE Initials _____

Patient Consent to Obtain Medication History

Your Hill Country provider would like to include your medication history in your record. The list comes from places like your pharmacy and your health insurance.

An accurate medication history is **very important** and helps us give you safe care and avoid potential dangerous medicine reactions.

The list may not include vitamins, supplements, herbal products, or medicines you buy without a prescription. Please tell us about all medicines you take and let us know if anything on the list is not correct.

Please initial your choice and sign below.

_____ **I give permission** for Hill Country Community Clinic to get my medication history from my pharmacy, health insurance (including state or federal programs), and other health care providers. This information may be added to my medical record if my provider feels it is needed for my care.

OR

_____**I DO NOT give permission for** Hill Country Community Clinic to get my medication history from my pharmacy, health insurance, or other health care providers.

By signing this consent form without making a selection, you are consenting to giving permission to Hill Country Community Clinic to obtain medication history from locations stated above.

PATIENT SIGNATURE: (or Parent/Guardian)	►	**DATE:**

Conflict of Interest Disclosure

If there is anyone employed at Hill Country Community Clinic that you do not want to have access to your medical, dental, or behavioral health records, please list their names and the reason why:

1. _____
   _____
2. _____
   _____

A representative from our office may contact you for more information. All information disclosed is kept confidential and used only to keep your personal information secure

Hill Country Community Clinic
Patient Rights and Responsibilities

Hill Country Community Clinic (HCCC) is dedicated to healing the whole person by providing you with high quality, compassionate, integrated health care. By signing this agreement, I agree to be an active member of my health care team and acknowledge my rights and responsibilities as a patient.

You have the right to:

- Respectful treatment and privacy
- Choice and involvement in your care
- Access to primary health care services
- Access to specialty services outside of HCCC
- Access to your medical records
- Information in your primary language
- Understand your treatment options
- File a grievance without worry of retribution

You have a responsibility to:

- Schedule appointments when you need medical care
- Cancel appointments 24 hours prior appointment date / time
- Request timely medication refills 72 business hours before they are due
- Cooperate with your health care team and play an active part in your care planning (e.g. labs, diagnostic imaging, follow-up care)
- Treat all HCCC employees, including your provider, with respect and common courtesy

We are committed to working with you, and if at any point you cannot meet your patient responsibilities, we will meet with you to create a plan for continued care.

Patient Signature_____ **Date**_____

Provider Signature_____ **Date**_____

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Chart #_____

Hill Country Health And Wellness Center
29632 Highway 299 East Round Mountain, CA 96084
(530) 337-6243 Fax: (530) 337-6655

CONSENT TO TELEMEDICINE

Name: _____ **Date of Birth:**_____

In compliance with Business and Professions Code Section 239.5 the health care practitioner, who has "ultimate authority over the care on primary diagnosis of the patient," must obtain verbal and written informed consent from the patient or the patient's legal representatives.

I hereby consent to and authorize Hill Country Community Clinic to use telemedicine in the course of my diagnosis and treatment. I understand that telemedicine involves the communication of my medical information to physicians and other health care practitioners located in the State of California by means of interactive video, audio, and/or data communications, including medical images and electronic readings.

Right to Withdraw Consent: I understand that I can withhold or withdraw my consent at any time. I understand that my withdrawal or consent will not affect any right to future care or treatment, not will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.

Confidentiality: I understand that the laws that protect the confidentiality of medical information apply to telemedicine. No patient-identifiable images or information from my telemedicine interaction will be disseminated to researchers or other entities without my consent.

Access to Information: My right to access all medical information transmitted during a telemedicine consultation is guaranteed and copies of this information are available to me for a reasonable fee.

_____ _____

Signature **Date**

_____

For Minors, Signature of Parent/Guardian (please state relationship)

AGREEMENT TO RECEIVE CCBHC SERVICES AND CONSENT TO PARTICIPATE IN DATA COLLECTION

NOTICE TO PATIENTS/CLIENTS

About the CCBHC Program…

Through a grant from the Federal Department Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), our organization has established a Certified Community Behavioral Health Clinic (CCBHC). The purpose of the CCBHC is to provide patient-centered integrated services, including access to crisis intervention services 24/7 for individuals with serious mental illness (SMI) or substance use disorders (SUD), including opioid use disorders; children and adolescents with serious emotional disturbance (SED); and individuals with co-occurring mental and substance disorders (COD). Our organization's CCBHC will provide comprehensive 24/7 access to community-based mental and substance use disorder services; and treatment of co-occurring disorders. Your participation in this program is **completely voluntary,** and you may stop services at any time.

What you should expect...

As a CCBHC, we are required by SAMHSA to collect information on patients/clients who receive services at our CCBHC. The information collected is only done so to help us show that our CCBHC is effective at serving our patients/clients. If you accept services at the CCBHC, you will be asked to provide confidential information, which we will not share directly with SAMHSA or anyone else in any way that identifies you. Your participation will be strictly confidential. The reports that we write will combine your personal information with others in the program so that no one individual can be known.

What you should know…

Because we are only reporting on combined data from all patients/clients collectively, it is highly unlikely that any information that we produce will in any way identify children or adults participating in the program. As with all medical information and medical records, we are committed to protecting your privacy. Furthermore, information gathered in the course of your participation is stored in secure locations that only selected individuals are permitted to access.

If you understand and are in agreement with these expectations, please sign your name below.

I, _____, agree to participate in the CCBHC program. I agree to provide information about myself, my child, and/or my family at intake and every six months. I understand that any information provided is strictly confidential and it will never be used to identify me. Participation in CCBHC services is completely voluntary; I understand that I can request to be discharged at any time. If I no longer wish to participate in the CCBHC, I am still eligible to be a patient/client at the organization and to receive other services.

_____ Date: _____

(*Participant's signature*)