VALLEY VIEW HEALTH CENTER

Welcome & Thank You for Choosing Valley View Health Center!

Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA). You will notice that we ask questions about race, ethnicity, gender, and sexual identity. We ask these questions of every patient**.** We do this so we can review the treatment that all patients receive and to make sure your clinic is providing culturally informed care. Valley View does report de-identified demographic, health, and financial information to organizations we receive grants from to evaluate the overall health of our communities. Your personal identification is not provided to these organizations.

Please understand that the legal name and gender listed in the patient contact section is for insurance purposes and must be used on documents pertinent to insurance and billing. Thank you!

Patient Contact Information

Legal Name (Last, First, Middle): Birthdate:

Social Security#:

Birth Sex: Male / Female Current Gender: Male / Female

Mailing Address:

Physical Address:

Cell Phone: Home Phone:

Email Address: _____@_____

Current Pharmacy (Name & Location):

Demographic Information

Preferred Language:_____

Sexual Orientation:

☐Straight/Heterosexual
☐Bisexual
☐Gay
☐Lesbian
☐Queer
☐Questioning
☐Decline to disclose
☐Other

Gender Identity:

☐Woman
☐Transgender woman
☐Man
☐Transgender man
☐Non-binary
☐Intersex
☐Gender queer
☐Decline to disclose
☐Other

Housing Status:

☐Homeless
☐Permanent Home/ Renting
☐Decline to Answer

Veteran Status (Have you been in the military?)

☐Yes ☐No

Ethnicity (Are You Hispanic/Latino?)

☐Yes ☐No ☐Unknown

Race (Check All that Apply):

☐Asian ☐ Alaska Native/American Indian
☐Black/African American ☐Native Hawaiian
☐Pacific Islander ☐White ☐Unknown
☐Decline to Answer
☐Other:_____

Marital Status:

☐Single ☐Life Partner ☐Domestic Partner
☐Married ☐Divorced ☐Widowed
☐Legally Separated ☐Unknown/Decline
☐Other: _____

Agricultural Worker (In the last two years have you or your family worked in fields, orchards, greenhouses, farms, vineyards, packing house, or with animals, such as cattle, dairy, sheep, poultry, fish hatcheries) ☐Yes ☐No

Migrant Worker (In the last two years you or your family **moved** to work in fields, orchards, greenhouses, farms, vineyards, packing house, or with animals, such as cattle, dairy, sheep, poultry, fish hatcheries) ☐Yes ☐No

VALLEY VIEW HEALTH CENTER

Individual Responsible For Payment		☐Same as Patient Contact Information
Name (Last, First, Middle):		Birthdate:
Relationship to Patient	SSN:	Phone #:
Mailing Address:		

Person To Contact In Event Of Emergency		
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

How Did You Hear About Our Clinic?

☐Friend/Family ☐Community Event ☐Hospital ☐Advertisement ☐Phone Book ☐Other: _____

Appointment Cancellation Policy

- If you are more than **(10) ten minutes** late for your appointment, you **may** be asked to reschedule.
- Please provide **at least 24 business hour notice** to cancel or reschedule an appointment.
- Appointments cancelled with less than 24 hours' notice will be noted as a "short term cancellation."
- If you have **(2) two missed appointments/short term cancellations within (6) six months. You may lose the right to schedule appointments for up to six months.** Care will still be available for any patients on Standby Status. Standby Status means that a patient must arrive before 8:00 am and wait for an open appointment.

I understand Valley View Health Center's Appointment Cancellation Policy **Initial here** _____

Business Office Requests

- Please present **current** insurance cards when you check in for your appointment.
- Payment or co-pay is expected at the time of service unless previous arrangements have been made.
- Children younger than 18 must be accompanied by a parent/guardian who stays at the clinic for the entire appointment. Minors (under 18 years of age) are not allowed to be left in our waiting room without adult supervision.
- **Insurance, DSHS and other assistance is an agreement between you and the insurance company or organization. YOU are responsible for payments not covered.**

Authorization to Pay Benefits to Valley View Health Center

I hereby authorize payment directly to Valley View Health Center for services I received. I understand that I am financially responsible to Valley View Health Center for services not paid by insurance or other third-party payers. **Initial here** _____

I agree to pay my co-payment at every visit: **Initial here** _____

Authorization to Release Information

I hereby authorize the release of all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits of service. A copy of this authorization shall be as valid as the original. **Initial here** _____

I acknowledge all provided information is accurate and true.

X _____ **Date** _____

SIGNATURE OF PATIENT/GUARDIAN or Witness (If adult patient is unable to sign)

VALLEY VIEW
HEALTH CENTER

Medical Record Number_____

Patient Financial Responsibility

We are dedicated to providing the best possible care for you and we want you to completely understand our financial expectations. As a courtesy, we will bill your insurance based on the information you provide us. If you do not have health insurance, we expect you to pay the full balance for services you receive.

Payment is required at the time of service, including co-pays, deductibles, service fees, and/or any non-covered services. We accept cash, check/debit cards, and most major credit cards. If you are unable to pay at the time of service, payment arrangements must be made with no additional administrative fees.

We will send you a statement for any additional balances owed. All account balances are to be paid 30 days from the statement date. **If you are unable to pay in full by that date, you should contact our Patient Account Specialist at (360) 330-9564 to discuss other resources that may be available to you.** We reserve the right to place any account on a cash basis. Failure to make payments or contact our Patient Account Specialist may result in collection activity.

Payment on your account may be made by the following methods:

1. Payment in full by cash, personal check, debit cards, and most major credit cards.

2. Interest free monthly payment plan that allows you to pay your bill. Please contact our Patient Account Specialist at (360) 330-9564 to discuss flexible payment arrangements.

3. Financial Assistance may be available to patients who are experiencing financial hardship for all or part of the healthcare that they received from any Valley View Health Center facility or service. All patients who feel that they may be eligible are encouraged to apply. Financial assistance application forms are available upon request and without charge.

4. Charges for covered services provided to uninsured patients may be eligible for an uninsured discount.

5. Charges for non-covered services due to out-of-network or non-credentialed, non-enrolled providers are due in full.

6. Cash payment-in-full discount is also available. Please contact our Patient Account Specialist at (360) 330-9564 to discuss if you are eligible.

By signing this form, I acknowledge and understand that I am responsible for paying for services received at Valley View Health Center.

_____ _____

Patient Name (Print) Date

_____

Patient, Parent, or Guardian Signature

STATEMENT OF PRIVACY PRACTICES

Valley View Health Center

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

If you'd like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.

Valley View Health Center
2690 NE Kresky Avenue * Chehalis, Washington 98532 - 360-330-9595

Valley View Health Center

Chehalis, Washington 98532

Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Valley View Health Center. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Valley View Health Center reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO", without indicating "YES" in answer to the each individual question. Personal protected information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse (*Name*)**:**	☐YES	☐NO
Any Member of my family (*i.e. Children, Children's Spouses, Parents, Grandchildren*) (*Name & Relationship*):	☐YES	☐NO
Immunization records with the school (*Name of School*):	☐YES	☐NO
Other*(please specify)*:	☐YES	☐NO
Name of patient (*please print*):	**Date of Birth**:	
Patient's Signature:	**Date**:	
Patient's Personal Representative's (*please print*)**:**		
Personal Representative's Signature:	**Date**:	
Representative's Telephone Number:		

OFFICE USE ONLY BELOW THIS LINE

ACKNOWLEDGMENT NOT OBTAINED				
Provided Prior to Treatment		☐YES	☐NO	Date Statement Provided:_____
Reason for not obtaining patient signature	☐	Needed more time to review Statement of Privacy Practices		
	☐	Wanted to consult another person before signing		
	☐	Physically unable to sign		
	☐	No reason offered		
	☐	Other:_____		

VALLEY VIEW HEALTH CENTER

Family Size & Income

Patient Name: _____ Date of Birth:_____

Social Security:_____ _____ Today's Date:_____

Valley View Health Center receives funding based on the information provided on this form. Even if you are not applying for the *discount*, please complete the **Family Size & Income** information to help us meet our grant reporting requirements. *Thank You!*

Please list spouse, significant other, and dependents even if you are not applying for the *discount*.

Name	Relationship to you	Type of income	Monthly gross income
	Self		
		Total income:	

Note: Please include income documentation for each individual listed that has an income. Copies of tax returns, last two pay stubs, or other information verifying income are required before a *discount* is approved.

Samples of type of income:

- Employment
- Disability
- Unemployment
- Child Support
- Self-Employment
- Savings
- Social Security
- VA Benefits
- Spousal Support
- Public Assistance/food stamps
- Training Stipends
- Housing Allowance
- Scholarships/Grants
- Military Family Allotments
- Other
- Support from an Absent Family Member

If your income is $0, how are you meeting your food, clothing shelter and transportation needs?

_____

Discount

It is the policy of Valley View Health Center to provide services regardless of an individual's ability to pay. A *discount* is offered based on family size and annual income. Please complete and initial all information and return to the front desk to determine if you or members of your family are eligible for a *discount*.

- **I understand that I am responsible for payments after qualifying for the discount.** *Initial here* _____
- **I understand that some services may not be covered under this discount.** *Initial here* _____
- **I understand that accounts more than 90 days past due may be sent to collections.** *Initial here* _____
- **I understand that I need to bring in Proof of Income(POI)within 30 days.** *Initial here* _____

I certify that the Family Size & Income information provided is correct. I give Valley View Health Center permission to verify this information. This form must be completed every 12 months **or** if your financial situation changes.

Name/Guardian: _____ Signature: _____ Relationship to patient: _____

Office Use Only

Staff Name:_____

Income Verification Provided:

☐ Prior year tax return ☐ Two (2) most recent pay stubs ☐ Supporting letter with Manager's initials_____

☐ Other: _____

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Patient Name:_____ **DOB:**_____ **DATE:**_____

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Please give this document to the Medical Assistant or Nurse when they call you back.

- Does someone have power of attorney or healthcare proxy giving them the power to make decisions about your care in life-threatening situations? ☐Yes ☐No *If yes, please provide us with a copy.*
- Do you have an Advanced Health Directive, such as do not resuscitate? ☐Yes ☐No
- If no, do you want to discuss this with your provider today? ☐Yes ☐No

Allergies: Please check all that apply. List additional allergies, if needed.

	Antibiotic (please specify):
	Codeine
	Iodine/Shellfish
	Latex
	Other:

Medical History: Please check all that apply

	Allergies		Blood Clots		High cholesterol		Irritable bowel disease
	Anemia		Cancer		Gallbladder disease		History of heart attack
	Angina		Arrhythmia		Headache/migraines		Osteoporosis
	Anxiety		COPD		Heart disease		Renal (Kidney) disease
	Arthritis		Artery disease		Hepatitis/Liver disease		Seizure disorder
	Asthma		Depression		High blood pressure		Stroke
	Atrial Fibrillation		Diabetes		HIV		Thyroid disease

- Have you had any recent specialist or hospital visits? ☐Yes ☐No

Current Medications: (*Please list all prescription AND over the counter medications*)

Medication Name	**Dose**	**Frequency of Use**

If you need more room, use the back side of the last page or provide a written medication list to your nurse.

VALLEY VIEW
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Patient Name:_____ **DOB:**_____ **DATE:**_____

Family Medical History

Please check all that apply and specify the relationship to you, if they are deceased, and age of death (if applicable).

Condition	Relationship	Deceased? (Yes/No)	Age of Death?
Alcoholism			
Alzheimer's			
Asthma			
Blood Disorders			
Cancer/ Type:			
Cardiovascular (Heart) Disease			
Coronary Artery Disease			
Coronary Heart Disease			
Depression			
Diabetes			
Hypertension			
Mental Illness			
Migraines			
Osteoporosis			
Renal Disease			
Seizure Disorders			
Stroke			
Thyroid Disease			
Other:			

Operations and/or Hospitalizations:

	Angioplasty		CABG		Gastric Bypass		Uterine Fibroids
	Appendectomy		Pacemaker		Hernia Repair		ORIF
	Arthroscopy		Carpal Tunnel Release		Hip Replacement		Thyroidectomy
	Back Surgery		Cataracts		Hysterectomy		Tonsillectomy
	Tubal Ligation		Gallbladder		Knee Replacement		Other:
	Blood Transfusion		Colon surgery		LASIK		
	Breast Augmentation		D&C		Mastectomy		

Vaccinations:

Date of Last Tetanus Vaccination: ___/___/____

Date of Last Flu/Pneumonia Vaccine: ___/___/____

VALLEY VIEW
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Patient Name:_____ **DOB:**_____

Preventative Health Screenings (as applicable)

Date of Last Well Visit: ___/___/___
Date of Last Dental Visit: ___/___/___
Date of Last Colonoscopy: ___/___/___ ___ Check here if not applicable
Date of Last Eye Exam: ___/___/___ ___ Check here if not applicable
Date of Last PAP: ___/___/___ Results: ___Normal ___Abnormal ___ Check here if not applicable
Date of Last Mammogram: ___/___/___ Results: ___Normal ___Abnormal ___ Check here if not applicable

Over the last 2 weeks how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

Substance Use History

- Do you drink caffeinated products? ☐Yes ☐No
- Do you drink alcohol? ☐Yes ☐No ☐Former
- Do you use tobacco products? ☐Yes ☐No ☐Former
- Do you use e-cigarettes? ☐Yes ☐No ☐Former
- If yes, have you ever tried to quitting tobacco products? ☐Yes ☐No/Never
- If you are a former tobacco user, how long ago did you quit? _____

Confidential Health History

*This information is confidential and **not** included in your social history information.*

- Are you Sexually Active? ☐Yes ☐No
- Do you practice safe sex? ☐Yes ☐No
- Are you on PrEP? ☐Yes ☐No
- Have you ever used drugs? ☐No ☐Yes If yes, what:_____
- Do you smoke marijuana? ☐Yes ☐No

- **Abuse/Domestic Violence History**:
- Have you ever felt afraid/threatened/controlled by a partner, family member, or caregiver? ☐Yes ☐No

Thank you for answering this comprehensive health history form. Your answers are confidential and will help us provide more complete and knowledgeable care of you.