LOS ANGELES CHRISTIAN HEALTH CENTERS

Los Angeles Christian Health Centers

Patient Registration Form

PATIENT INFORMATION

Date:	**Last Name:**	**First:**
Address ❑ Home ❑ Work ❑ Mailing :		
Apartment Number :	**City:**	**Zip Code:**
Home Phone:	**Cell Phone:**	**Work Phone**:
Responsible Party: ❑ Self **OR** **Name:** **Relation to Patient :**		**Patient Date of Birth** / /

Sexual Orientation:
- ❑ Straight ❑ Bisexual
- ❑ Choose Not to Disclose
- ❑ Lesbian or Gay
- ❑ Something Else
- ❑ Other : _____

Gender Identity:
- ❑ Female
- ❑ Male
- ❑ Transgender
- ❑ Other
- ❑ Choose Not to Disclose

Social Security Number:

Gender at Birth:
- ❑ Female
- ❑ Male

Marital Status:
- ❑ Married
- ❑ Single ❑ Divorced
- ❑ Legally Separated

Emergency Contact Name : Phone:

Address: Relation:

Ethnicity:
- ❑ Hispanic
- ❑ Non-Hispanic
- ❑Refused to Report / Unreported

Are you a veteran?

❑ Yes ❑ No

Race:
- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Black or African American
- ❑ White
- ❑ Other Pacific Islander
- ❑ Native Hawaiian
- ❑ More than one
- ❑Refused to Report / Unreported

Language:
- ❑ English ❑ Indic Language
- ❑ Korean ❑Armenian
- ❑ Spanish ❑ Chinese ❑ Hmong
- ❑ Urdu ❑ Cambodian ❑ Japanese
- ❑ Arabic ❑ Portuguese
- ❑ Vietnamese
- ❑ American Sign Language

Other:_____

Patient authorization for contact:
- ❑ Detailed message on my home phone
- ❑ Call back number only on my home phone
- ❑ Detailed message on my cell phone
- ❑ Call back number only on my cell phone
- ❑ Letter/mail sent to my home address
- ❑ Letter/mail sent to my work address
- ❑ Text message to my cell phone
- ❑ Email / portal message

Please share your email address:

Email address:_____

Where do you live:
- ❑Own Apt/Home
- ❑Shelter:_____
- ❑Transitional Housing
- ❑ With Family/Friend
- ❑ Street
- ❑ Permanente Supportive Housing: (You pay a portion of your income for rent and you get services at no cost).
- ❑ SRO/Other: _____

Public Benefits:

Mark all that apply
- ❑ General Relief ❑ Food Stamps
- ❑ Cal-WORKS ❑ Voucher Program
- ❑ Social Security Income
- ❑ VA Benefits
- ❑ SSDI Disability ❑ Unemployment

Other Forms of Income:
- ❑ Retirement ❑ Child Support
- ❑Pension
- ❑ Other

LOS ANGELES CHRISTIAN HEALTH CENTERS

FINANCIAL INFORMATION

Please give the receptionist your Medi-Cal, Medicare, Insurance Card and Picture ID, if applicable.

Household Monthly Income:	**Private Insurance:** ❑ PPO / Commercial Insurance:	**Coverage Options:** mark all that apply
$	Subscriber ID:_____	❑ Medi-Cal
	Relationship to	❑ Medicare
Total Family Size:	Subscriber:_____	❑ HMO
		❑ My Health LA

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Los Angeles Christian Health Centers. I understand that I am financially responsible for any balance. I also authorize Los Angeles Christian Health Centers or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____	**Date:** / /

CONSENT TO TREATMENT

I, _____, consent and understand the following for myself or minor _____:

1. Consent to treatment. By signing below, I consent for myself (or minor previously stated), to health care including routine diagnostic procedures, medical and dental treatment and other health care services given to me by Los Angeles Christian Health Centers and its authorized agents and personnel.
2. No Guarantees: I understand that the practice of medicine and surgery and the giving of health care is not an exact science. No guarantees have been made as to the results of treatments, examinations and/or other healthcare services given by Los Angeles Christian Health Centers and its authorized agents and staff.
3. I understand it is the policy of Los Angeles Christian Health Centers to provide essential services, examinations, medications and other health care related services regardless of the patient's ability to pay. However, when appropriate, third party billing may be made on my behalf to agencies and programs both public and private that will reimburse for such services. I understand that my health information may be used to pursue such reimbursement for treatment and/or health care operations. I understand I have the right to review Los Angeles Christian Health Centers' policies and procedures on patient confidentiality.
4. I understand that if I do not qualify under the discount program due to having Health Insurance and/or being above the 200% poverty level, I will be financially responsible for any medical services and medications provided to me.
5. I understand that this consent to treat form will be in effect until such time that I revoke my consent in writing.
6. I understand that I have a right to a copy of this consent to treat form.
7. I have received Los Angeles Christian Health Centers Notice of Privacy Practices.
8. I have received Advance Directive Information
9. I understand that I have the right to accommodations based on my disabilities. For example, if I am unable to read a document due to visual problems, every attempt will be made to assist with reading the document. As an alternative, I have a right to take the document, read it at home, and complete and return the document at a later time
10. I give consent to Los Angeles Christian Health Center to bi-directionally share my information electronically with health care providers, hospitals, and Health Information Exchange (HIE). ❑ Check this box to OPT out (Electronic Data Access Denial form given).

_____ _____

Patient or Parent/Guardian Signature **Date**

_____ _____

LACHC Staff Witness to Signature **Date**

Los Angeles Christian Health Centers
Discounted/ Sliding Fee Application

The **Los Angeles Christian Health Centers'** (LACHC) policy is to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and income. Please complete the following information and return to the Front Desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at Joshua House, Pico Aliso Community Clinic and outreach sites, except health professional physical exams which includes students in the health professions.The discount approved will be valid for one year or until there is a significant change in your income, family size or health insurance coverage. If that happens, you must re-apply. Please inquire at the Front Desk if you have questions.

I certify that the family size and income information shown on this application are correct. I understand that **one of the following four** is needed before a discount is approved:

1. Three current payroll stubs, or 2. Copy of last year's tax return, or 3. Copy of most recent statement from any cash assistance program 4. Self-Declaration of Income.

I agree that I if I do not qualify for any discount, I am responsible to pay for all services I am to receive.

Signature_____ **Date**_____

	Application Date		
Last Name	**First Name**		**Middle Initial**
Street Address	**City**		**Zip Code**
Home Phone			
Cell Phone			
Social Security Number			
Drivers License (if no Social Security Number)	**State**		
	Number		
DMV Identification Card (if no driver's license)	**State**		
	Number		

Relatives at Your Residence			
	Who	**Number of Persons**	**Estimated Monthly Income**
1	**Yourself**	1	
2	**Spouse**		
3	**Other Relatives**		
	Total		

Relatives: Include persons related by birth, marriage, or adoption who live with you. Also include college students who you support and are related to you by birth, marriage, or adoption, even if they don't live with you.

Income: Include income from all related persons in household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans payments, net business or self employment, alimony, child support, military, unemployment, public aid, and other.

Office Use Only					
Discounted fee (circle one)	A	B	C	D	No Discount
Approved Rate Good Until (Date)					
Approved by			**Date**		

LOS ANGELES CHRISTIAN HEALTH CENTERS

SELF-DECLARATION OF INCOME FORM

I _____, *living at*

_____

certify through my signature that the statement given below is true and correct to the best of my knowledge and belief: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature

ANY PERSON WHO SIGNS THIS STATEMENT AND WHO WILFULLY STATES AS TRUE ANY MATERIAL MATTER WHICH HE KNOWS TO BE FALSE IS SUBJECT TO THE PENALITIES PRESCRIBED FOR PERJURY IN THE PENAL CODE BY THE STATE OF CALIFORNIA, SEC 11054 OF THE W. & 1. CODE.

LACHC Staff Use Only

_____	_____	_____
WITNESSED AND VERIFIED BY	CLINIC MANAGER	DATE

Revised 6/19/18

LOS ANGELES CHRISTIAN HEALTH CENTERS

CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Use & Disclosure of Your Protected Health Information (PHI):

Your Protected Health Information (PHI) may be used by Los Angeles Christian Health Center (LACHC) or disclosed to others only for the purpose of your healthcare treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. Protected Health Information (PHI) will otherwise not be disclosed without your express written consent.

You have the right to view your PHI and can request a notice of disclosure detailing when, to whom, for what purposes, and what content of your PHI has been distributed (some restrictions apply).

Requesting a Restriction on the Use or Disclosure of Your Information:

You have the right to ask that we limit how we use/disclose your PHI. For example, you could ask that we not disclose information about a surgery you had. In your request, you must tell us 1) what information you wish to limit and 2) to whom you want the limit to apply.

We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use or disclosure of your PHI, we will put the agreement in writing and abide by it except to provide emergency treatment. We cannot agree to limit uses or disclosures that are required by law or that have occurred prior to the written request.

Revocation of Consent:

You may revoke this consent in writing. Any use or disclosure that has already occurred prior to the date which your revocation is received will not be affected.

Notice or Privacy Practice:

You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. You may review the notice prior to signing the consent, and you may request a copy for you records.

Reservation of Rights to Change Privacy Practices:

Los Angeles Christian Health Centers reserves the right to modify the privacy practice outlined in its Notice of Privacy Practice.

LOS ANGELES CHRISTIAN HEALTH CENTERS

PATIENT RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

(please print)

In general the HIPAA privacy rule gives individuals the right to appeal a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications of that communication of PHI is made alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I have reviewed this consent form and give permission to the Los Angeles Christian Health Centers to use my Protected Health Information (PHI) in accordance with it.

patient name (*print*) _____ patient signature _____

guardian/person responsible signature _____ relationship to patient _____

witness _____ date _____

PATIENT RECORD OF DISCLOSURES

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record. **Note: Uses and Disclosures for TPO may be permitted without prior consent in an emergency.**

DATE:	DISCLOSED TO WHOM (*Address or Fax Number*)	DESCRIPTION OF DISCLOSURE, PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED

LOS ANGELES CHRISTIAN HEALTH CENTERS

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT

I acknowledge receipt of the Notice of Privacy Practices from the Los Angeles Christian Health Centers.

patient name *(print)*	patient signature	date
guardian or conservator name *(print)*	guardian or conservator signature	date
staff/witness name *(print)*	staff/witness signature	date

INABILITY TO OBTAIN ACKNOWLEDGMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why acknowledgement was not obtained.

patient's name

Reasons why the acknowledgement was not obtained:

- ☐ Patient refused to sign this acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
- ☐ Other: _____

signature of provider representative | date

LOS ANGELES CHRISTIAN HEALTH CENTERS

ADVANCE DIRECTIVES

Advance Directives are Written Instructions Which Communicate Your Wishes About the Care and Treatment You Want If You Reach a Point Where You Can No Longer Make Your Own Health Care Decisions

All health care facilities that receive Medicare and Medi-Cal payments must provide patients with written information concerning: 1) their right to accept or refuse treatment and 2) their right to prepare advance directives. The law does not require that you actually have or make an advance directive.

Under California law adult persons with decision-making capabilities have the right to accept or refuse medical treatment or life sustaining procedures. Artificial nutrition and hydration are among the medical procedures you have the right to accept or refuse.

Reason Why You May Want to Prepare an Advanced Directive

- To ensure you receive the care and services you desire.
- To ensure the refusal of treatment at a determined stage if you have previously stated your desires to do so.
- To designate the person you would like to make decisions on your behalf.
- To ensure that family and friends understand your wishes regarding health care. If you do not make your decisions clear, your family member and friends may not agree about what type of treatment you want. It is possible your desires will not be carried out, since a conflict may lead to a lengthy court delay.

Being Prepared With an Advance directive, You Can say WHAT Types of Treatment You Want, and WHO You Want to Speak For You.

THE NATURAL DEATH ACT

This is another type of advanced directive often called a "Declaration". This document DOES NOT require you to appoint an agent to make health care decisions for you.

The Declaration is for terminally ill patients. While you still have decision-making capabilities, you may sign a Declaration, which tells your doctors that would prolong the dying process. The Declaration must be followed in these circumstances:

- If you fall into a permanent unconscious state or a terminal condition (certified by two doctors).
- At the time you cannot make your own health care decisions.

Those persons who are witnesses to the signing of the Declaration must meet the same requirements as those needed for the Durable Power of Attorney for Health Care.

THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This is a legally binding document that allows the person you choose (the "agent") to make health decisions for you if and when you are no longer able to make such decisions. You should select a person who knows you well and whom you trust. Your agent may be a relative or a friend. The Durable Power of Attorney for Health Care allows your agent to make any and all health care decisions for you once you are no longer able to decide. This includes routine medical decisions, as well as more complicated decisions. If you give your agent authority, your agent can decide to withdraw or withhold life-sustaining procedures.

To be valid, the document must be signed by you and witnessed by two qualified adult witnesses.

Persons not eligible to be witnesses are your doctor, nurse, their employer or any other health care professional.

You do no need a lawyer to fill out a Durable Power of Attorney for Health Care.

The Durable Power of Attorney for Health Care allows you, in writing, to declare your desire to receive life-sustaining treatment under certain conditions. You may list any instructions you want pertaining to health care.

Do I Need a Special Form for This Durable Power of Attorney For Health Care?

YES. You must use a *Durable Power of Attorney for Health Care* form, not a plain Durable Power of Attorney. You can ask your physician, nurse or social worker about the form.

The California Medical Association has printed forms that meet the legal requirements:
California Medical Association
P.O. Box 7690
San Francisco, CA 94120 – 7690
ph: (415) 882–5175 or visite their website at: www.cma.org

Many stationary stores carry the forms. There is a small charge for these forms from all sources.

OTHER DOCUMENTS

Other documents that help determine your health care desires IF and WHEN you are UNABLE to make such decisions for yourself:

- **"DO NOT RESUSCITATE"** – This form allows your doctor to with-hold "resuscitative measures", should you desire. This should be signed by you, your doctor and a surgeon. The law does not require witnesses and notarization. NO ONE CAN MAKE YOU SIGN A "DO NOT RESUSCITATE" ORDER.
- **"PREFERRED INTENSITY OF CARE"** – This is a document of your preference for health care under special circumstances. A discussion with your attending physician and/or legal representative occurs prior to creating this document.
- **"LIVING WILL"** – This document lists your desires to receive or not to receive life-sustaining medical treatment under certain circumstances. A living will is NOT a legally binding agreement, although it is often accepted as an accurate statement of one's wishes.

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

notice is effective May 09, 2014 and was last update 4/12/2018.

This Notice of Privacy Practices applies to the following organizations.

Bettina Lewis, COO
311 Winston Street, Los Angeles, CA 90013
(213) 893-1960