HI-DESERT FAMILY HEALTH CLINICS
HI-DESERT MEMORIAL HEALTH CARE DISTRICT

PATIENT INFORMATION

58375 29 Palms Hwy., Yucca Valley, CA 92284
Phone: (760) 365-9305 Fax: (760) 365-9309

PATIENT'S INFORMATION

NAME (Last, First, Middle)			HOME PHONE NUMBER	
SSN	BIRTHDATE	SEX	EMAIL ADDRESS (IF APPLICABLE)	CELL PHONE NUMBER

PATIENT'S ADDRESS

STREET ADDRESS			P.O. BOX (IF APPLICABLE)		
CITY	STATE	ZIP	CITY	STATE	ZIP

WHAT IS YOUR PREFERRED METHOD OF CONTACT?

☐ HOME PHONE ☐ CELL PHONE ☐ TEXT ☐ POST MAIL ☐ EMAIL ☐ OTHER:

We will make every effort to contact you using your preferred method; however you may receive information from us by any of these methods. In the event we cannot reach you by your preferred method, do you have a relative or friend we could contact? If so, please provide that information below. Your signature at the end of this form provides your release and authorization for disclosure of your personal health information to the person(s) noted below. If you do not wish to grant this authorization to alternate contact persons, please leave this section blank.

ALTERNATE CONTACT PERSON(S):

NAME	CONTACT PHONE NUMBER	ALTERNATE PHONE NUMBER
EMAIL ADDRESS	IS TEXTING OKAY? ☐ YES ☐ NO	RELATIONSHIP
NAME	CONTACT PHONE NUMBER	ALTERNATE PHONE NUMBER
EMAIL ADDRESS	IS TEXTING OKAY? ☐ YES ☐ NO	RELATIONSHIP
NAME	CONTACT PHONE NUMBER	ALTERNATE PHONE NUMBER
EMAIL ADDRESS	IS TEXTING OKAY? ☐ YES ☐ NO	RELATIONSHIP

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME	CONTACT PHONE NUMBER	ALTERNATE PHONE NUMBER
ADDRESS	CITY, STATE	RELATIONSHIP

ADVANCE DIRECTIVE

DO YOU HAVE A CURRENT ADVANCE DIRECTIVE ACKNOWLEDGEMENT ON FILE WITH US? ☐ YES ☐ NO ☐ UNSURE

IF YOU ANSWERED "NO" or "UNSURE", PLEASE SIGN & DATE THE ATTACHED ACKNOWLEDGEMENT & RETURN WITH THIS FORM

PATIENT'S ADDITIONAL INFORMATION *** VERY IMPORTANT *** Please read

Please take a moment to fill out EACH question in this section. As a Federally Qualified Health Center, Hi-Desert Family Health Clinics are required to submit annual reporting in each category. ****YOUR PERSONAL IDENTIFICATION WILL NOT BE TIED TO THIS REPORTING.****

ARE YOU HISPANIC OR LATINO? ☐ YES ☐ NO	**RACE** ☐ ASIAN ☐ AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ OTHER: ☐ HAWAIIAN/ISLANDER ☐ UNKNOWN ☐ WHITE	**LANGUAGE** ☐ ENGLISH ☐ SPANISH ☐ OTHER:	IS THIS THE LANGUAGE YOU PREFER TO USE WHEN DISCUSSING YOUR HEALTH CARE? ☐ YES ☐ NO *If no, explain:*
NUMBER OF DEPENDENTS *(claimed on taxes)* + SELF:	**MARITAL STATUS** ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ MARRIED ☐ SINGLE ☐ MINOR	**FAMILY INCOME:** $ ☐ WK ☐ MO ☐ YR	**VETERAN?** ☐ YES ☐ NO *If yes, select* ☐ ACTIVE ☐ RESERVE ☐ DISABLED
ARE YOU A MIGRANT WORKER? ☐ YES ☐ NO	**SEASONAL WORKER?** ☐ YES ☐ NO	**WHAT IS YOUR LIVING SITUATION?** ☐ HOMELESS SHELTER ☐ TRANSITIONAL	☐ NOT HOMELESS ☐ STREET ☐ OTHER

INSURANCE

TYPE OF INSURANCE:	POLICY OR I.D. NUMBER
NAME OF GUARANTOR (Responsible Party)	RELATIONSHIP TO PATIENT

1. Consent for Treatment: Having been admitted for out-patient services at Hi-Desert Family Health Clinics (HDFHC), I hereby consent to and authorize the administration of all emergency, diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending provider. ➡ _____ (initials)

2. Photography Consent: I consent to the taking of photographs, video tapes, digital or other images of my medical or surgical condition or treatment, and the use of the images for the purpose of my diagnosis or treatment or for the clinic's operations, including peer review and education or training programs conducted by the clinic. ➡ _____ (initials)

3. Authorization to Release Information: I hereby authorize HDFHC and all of my attending providers to release information and/or to facilitate the coordination of my health care with appropriate service providers. ➡ _____ (initials)

4. Authorization to Release Insurance Information: I hereby authorize HDFHC and all of my attending providers to release information to complete insurance claim forms. ➡ _____ (initials)

5. Assignment of Insurance Benefits: I hereby instruct and authorize my insurance carrier to make payments directly to HDFHC ➡ _____ (initials)

6. I understand that I am financially responsible for all charges. ➡ _____ (initials)

7. I have received a copy of the Hi-Desert Memorial Health Care District's **NOTICE OF PRIVACY PRACTICES.** ➡ _____ (initials)

MY RIGHTS

Right to Revoke	I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and submit it to the following address: Hi-Desert Family Health Clinic, 58375 29 Palms Hwy., Yucca Valley, CA 92284. My revocation will take effect upon receipt by Hi-Desert Family Health Clinic. I understand that the revocation will not apply to information that has already been released based on this authorization.
Expiration	Unless otherwise revoked, this authorization will expire on listed date. If I do not specify an expiration date, event, or condition, this authorization will expire one (1) year from signature.
Redisclosure	Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by the federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
Other Rights	I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CRF 164.524. I have the right to receive a copy of this authorization. If I have any questions about disclosure of my health information, I can contact the Privacy Officer at (760) 366-6476.

SIGNATURE

I have read and confirm the terms of access stated herein:

Signature of Patient or
Legal Representative: ➡ _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Print Name: _____
(Legal Representative)

☐ *Patient/Representative identification verified by:* _____ _____
Staff member's signature witnessing verification of ID *Date*