Health Service Alliance

To help us to give you the best care, we at Health Service Alliance (HSA) need to get to know you and ask that you complete this form to the best of your ability. If you need help filling out this form, please ask our staff for help.

☐ Mr. ☐ Mrs. ☐ Ms _____ _____ _____
Last Name **First Name** **Preferred Name**

_____ _____
Street Address/City/ State/Zip Code **Email**

Date of Birth: _____ **Age**: ____ **Gender**: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Contact Info: Home/Cell Phone: _____ Other Phone: _____
OK to text/voicemail/Email: ☐ Yes ☐ No

Social Security # _____ **Marital**: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐Widowed ☐ Other:_____

Racial/Ethnic Identification: ☐ Hispanic/Latino ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White/Caucasian ☐ Other: _____

Preferred Language:☐ English ☐ Spanish ☐ Cantonese ☐ Mandarin ☐ Tagalog ☐ Vietnamese Other:_____

Person to contact in case of an emergency: Name:_____

Relationship: _____ **Phone#**: _____ **Email**: _____

Total Monthly Income: _____ **Total # of persons in your household:** _____

Health insurance: ☐ None; Primary Insurance: _____ Secondary Insurance:_____

Reason for Seeking Care: ☐ Medical ☐ Behavioral Health ☐ Other: _____

Preferred Pharmacy: _____

Preferred Hospital/Date of most recent hospital stay: _____

Social History- Please check all boxes that apply. If you are not comfortable answering, skip to the next section.

Behavioral Health History: ☐ Yes ☐ No; if yes **Have you ever experienced/sought treatment for:** ☐ Depression ☐ Anxiety ☐ Substance Abuse Other:	**Highest level of school you completed:** ☐ Less than Grade 12 ☐ High School diploma/GED ☐ college ☐ Vocational certification ☐ Other: _____
Difficulty addressing basic needs: ☐ Yes ☐ No ☐ food ☐ finances ☐ housing ☐ Transportation ☐ Utilities ☐ Other: _____	**Incarceration History:** ☐ Yes ☐ No ☐ Currently on probation ☐ Currently on Parole ☐ Discharged
Disability/Assistance Needed: ☐ Yes ☐ No ☐ Need help with daily routines ☐ Need help with mobility ☐ Need help with reading/writing ☐ Other: _____	**Employment:** ☐ Employed ☐ Unemployed ☐Retired ☐ Student ☐ Disabled Other: _____
	Military service: ☐ Yes ☐ No ☐ Active Duty ☐ Discharged
Domestic Violence/Victim of Crime: ☐ Yes ☐ No	**Safety concerns with current living environment** ☐ Yes ☐ No ☐

☐ Yes ☐ No- I would like to speak with HSA staff about possible resources for any of the concerns above.

Acknowledgement- Please check appropriate box:

☐ I have filled out this form to the best of my ability and have no questions about this form, or

☐ I have filled out this form to the best of my ability but need help understanding some of the words or questions on this form. I will follow with the HSA staff and/or the treating clinician to get my questions answered.

Patient Name: _____ Signature: _____ Date: _____

Patient is unable to consent to treatment due to:

☐ Patient is an adult but lacks capacity to give consent; consent will be signed by designated decision maker as indicated by patient, patient's Power of Attorney/Advance Directive or court-designated conservator. Copy of Power of Attorney/Advance Directive or conservatorship will be requested and placed on the patient record.

☐ Patient is a minor and does *not* meet any of the following legal categories to make own consent:

- Patient is not emancipated by court order
- Patient is not 15 or older and cannot demonstrate self-sufficiency
- Patient is not active military
- Patient has never been married
- Patient is not 12 or older and seeking care for pregnancy care or termination of pregnancy, communicable diseases, sexual assault/rape, mental health, or drug/alcohol abuse.

If patient is unable to sign this form or does not make own decisions, please write name of person acting in the patient's behalf and sign below.

Name of person acting in patient's behalf: _____

Relationship to Patient: _____

Signature: _____ Date: _____

For Staff Only:

1. If patient has checked any boxes in Social History, please verify with the patient if they would like to speak with staff about community resources and refer to Case Management as appropriate.
2. If the patient is unable to provide consent, please ask for a copy of the Health Care Power of Attorney document if completed or a copy of the court order if the patient has a conservator.
3. If the patient is a minor and able to provide consent under the legal requirements for emancipation, please request a copy of the court order or other documentation.
4. If the patient is a minor and able to provide consent under the legal requirements for self-sufficiency, please have the minor complete and sign the form for "Self-Sufficient Minor" (available in HSA forms or in the California Hospital Association Consent Manual).

ACKNOWLEDGEMENT AND CONSENT FOR HSA SERVICES REV 5/2021

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

The Mission of Health Service Alliance (HSA) is to provide you with quality health care, behavioral health and case management services. Our goal is to ensure that all members of our community receive care in a manner that best meets your needs, regardless of religion, ethnicity, race, or gender. To help serve you better, we are required to provide certain information and guidelines to you. Please read the information below and initial each section. If you need help understanding this information, our staff will be glad to assist you.

_____ **Initiation of Services-** I agree to provide requested information to the HSA staff to help them better understand my needs and to cooperate to the best of my ability with care recommendations.

_____ **Hospital Admissions/ER Visits-** I agree to notify HSA every time I seek care at a hospital and will provide my HSA physician with copies of my hospital records.

_____ **Confidentiality-**I understand that all of my information, including my health care information, will be kept private and confidential unless I provide written authorization for it be shared with someone else, except when my information must be released for legal reasons. These reasons include:

- A court order requires HSA to release information;
- I'm in danger of self-harm or of harming others;
- I'm a possible victim of abuse or neglect.

_____ **Confidentiality- Substance Abuse and/or Behavioral Health Records:** I understand that this clinic offers a variety of services and because of this, staff is allowed to view all of my records as a part of providing full scope care. If I have questions/concerns regarding this practice, I will discuss this with my provider.

_____ **Notice of Privacy Practices-**I have been provided a Notice of Privacy Practices which explains in greater detail my rights to privacy and how I can access my records. The HSA staff has answered my questions regarding this Privacy Notice, and I consent to releasing my information to my health plan for the purpose of billing claims, certification, case management, quality improvement, benefit administration and other related purposes.

_____ **E-Mail Disclaimer-** I understand that, if I provide HSA with my e-mail address, I am authorizing this as a form of communicating medical information to me, my representatives and other health care providers involved in my case. If I choose not to allow this type of communication, I will provide a written notification to prohibit this.

_____ **Emergency Access-** HSA has after-hours clinicians available to handle emergencies. I understand that my provider will discuss after-hour procedures with me, and for life-threatening emergencies, I will call 9-1-1 or go to the nearest emergency room.

_____ **Financial Terms/Insurance Coverage and Co-pays-** I understand that I may be responsible for obtaining insurance authorization, if needed, for my treatment as well as any co-pays and deductibles. HSA will assist me if I do not understand what steps I need to take and will answer my questions regarding coverage.

_____ **Cancellations and Missed Appointments-** I understand that HSA makes every effort to accommodate my schedule by providing appointment times and reminders. If I do not cancel my appointments by noon the day before my appointment, I may be charged for this cancellation. I further understand that my insurance will not cover cancellation fees. If I repeatedly miss

appointments, HSA will discuss with me whether a referral to another provider may be more appropriate for me.

_____ **Fees for Paperwork-** I may have documents that need completion by a health care provider, and I understand that there may be a fee for this request. I recognize that this is a normal part of doing business and agree to pay the fees expected.

_____ **Advance Directive and/or POLST-** I understand that it is important to have my health care wishes in writing should I become too ill to verbally communicate them. I have provided this documentation to the HSA staff for my records. If I do not have an Advance Directive or POLST, I will be provided additional education regarding this unless I specifically decline further education.

_____ **Medication Management-** I have provided HSA the name of a preferred pharmacy for my prescriptions and agree to only take any medications (prescribed or over the counter) and/or controlled substances as recommended. I acknowledge that, if I need a refill, I will request this at least 5 days in advance, and this may only be provided with physician authorization and if I have an nearing upcoming appointment. Further, some prescriptions cannot be called in and can only be provided at my office visit. I understand that, if I am seeking treatment to assist with substance use or medication management, these require regularly scheduled appointments to be successful with my treatment plan and I will keep these appointments to the best of my ability. (For patients seeking treatment for controlled substances, please see "Controlled Substance Agreement" Form).

_____ **Referrals Requiring Authorization:** HSA recognizes how important timely care is, which may include tests and treatment that need approval by my insurance. I understand that this process may take several days in order for my insurance to review my medical needs. I further understand that HSA will keep me updated regarding this process and answer any questions I may have.

_____ **Appeals and Grievances-** I have the right to appeal through my insurance when my care is not certified for coverage, and that there is no penalty to me in exercising this right. I also understand that I may submit a grievance to HSA or my insurance at any time that I want to file a complaint regarding my care. I further understand that I can contact the California Department of Managed Health Care at 800-400-0815 for complaints regarding my managed insurance or grievances regarding an appeal. If I do not have a managed insurance plan, I can also call the local Department of Public Health regarding my complaints or concerns regarding care- 909-383-4777.

_____ **Consent for Coordination with Insurance Company-** I authorize the release of information to my insurance company as necessary for coverage of my health care services at HSA. I further authorize use of my signature to file insurance claims and authorize my insurance to issue payment to HSA and its providers for services rendered.

_____ **Consent for Assessment/Diagnostic Work-up and Treatment-** I authorize and request for my health care or behavioral health care provider to provide all needed diagnostic and treatment services. that best meet my needs. I understand that, through the course of my treatment, my provider will explain all procedures to me and that they are subject to my agreement. I further understand that, while my treatment is intended to be helpful, each patient's response to treatment may be different, and care outcomes may vary.

_____ **Consent to allow Interns, under the supervision of a licensed clinician, to participate in and provide assessment, care planning and treatment-** I am aware that HSA is a teaching clinic and regularly includes interns as a part of its medical and behavioral health services. I agree to be treated by an intern, if

assigned, and recognize that, at any time, I have the right to revoke this consent by verbally notifying the HSA staff.

***Patient is an adult who:** □ makes own decisions □ is unable to make decisions and the following next of kin makes decisions in his/her behalf: _____ □ Has a medical Power of Attorney/Advance Directive that designates the following agent for decisions and a copy has been provided to HSA: _____ □ Has a court appointed Conservator who makes decisions and a copy of the court order has been provided to HAS. * See CHA Consent Manual for additional details regarding consent rules for Minors & incapacitated Adults.	***Patient is a minor and unable to consent.** Consent will be provided by: □ parent (biological or adopted- excludes step parent) If parents are divorced, parent has provided copy of custody order. □ Foster Parent or County Social Worker; copy of court order provided. □ Court ordered Guardian; copy of court order provided. **Patient is a minor and is able to consent as follows:** □ Pt is 12 or older is seeking care or prevention of a communicable disease, care for rape/ sexual assault, alcohol/drug abuse treatment, or outpt mental health treatment. □ Pt is married or previously married. □ Pt is emancipated by court order and has a DMV identification card. □ Pt is 15 or older and is self-sufficient- does not live with family and manages own affairs. □ Pt is seeking to prevent or treat pregnancy (excludes sterilization) or abortion. □ Pt is active duty with the military.

Patient Signature: _____ **Date:** _____

HSA Witness _____ **Date:** _____

HEALTH SERVICE ALLIANCE

Chino Valley Community Health Center
13193 Central Ave.
Chino, CA 91710
Phone: 909-464-9675
Fax: 909-590-3898

Montclair Community Health Center
5050 San Bernardino Street
Montclair, CA 91763
Phone: 909-281-5800
Fax: 909-281-5858

Chronic Care Management Consent

I agree to allow Health Service Alliance (HSA) to provide me with Chronic Care Management (CCM) services and to be designated as my CCM Provider. I also understand that other doctors may from time to time provide CCM services to me under this consent and will receive my medical information electronically from my CCM Provider through a computer system or fax.

I understand that only one doctor can provide CCM services for me each month and that I may have to pay a monthly co-payment charge.

I understand that these services will include, but may not be limited to:

- Consultation and guidance in managing my chronic conditions so I can be as healthy as possible,
- Reviewing my medications and addressing any questions I may have,
- Helping with scheduling office visits, tests, and other needed resources as recommended/ordered by my doctor,
- Receiving a plan of care with personal health goals,
- Sharing of my care plan with other doctors or providers that I see and the staff who are helping with my care, and,
- Working closely with home health and/or other healthcare resources in my area.

I understand that I can stop CCM services at the end of the month by contacting the office of my CCM provider, either by phone. If I choose to stop CCM services, I understand that I will no longer receive these services from my CCM provider, but this will not have any effect on my usual primary care services.

_____ _____
Name of Patient Date of Birth

_____
Name/Relationship of patient's representative if patient unable to Consent

_____ _____
Signature- Patient or Patient Representative Date

_____ _____
HSA Staff/Provider Witness Signature Date

Health Service Alliance

PATIENT RECORD OF DISCLOSURES

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

Date: _____

Re: _____

To Whom It May Concern:

I, _____ give permission to Chino Valley Family Physicians to give my personal medical information to my immediate family member (s) listed below.

1. _____ Relationship to patient: _____ Phone #: _____
2. _____ Relationship to patient: _____ Phone #: _____
3. _____ Relationship to patient: _____ Phone #: _____

I also wish to be contacted in the following manner (check all that apply)

Home Telephone: _____

- ☐ OK to leave messages with detailed information
- ☐ Leave message with callback number only

Work Telephone: _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

Written Communication:

- ☐ OK to mail to my home address

This authorization will be effective June 14, 2011 through _____.

Print Name: _____ Patients Signature: _____ Date: _____

Print Name: _____ Witness Signature: _____ Date: _____

Health Service Alliance

ADVANCED DIRECTIVE QUESTIONNAIRE

1). Have you formulated an Advance Directive? YES _____ NO_____

2). If you have formulated an Advance Directive, please check the type that you have

a) Durable Power of Attorney for Health Care: _____

b) California Natural Death Act : _____

c) Living Heath Care Will: _____

d) Other: _____

3). If you have formulated an Advance Directive, you hereby agree to furnish _____ with a copy within _____ days.

4). If you change, amend, alter or cancel your Advance Directive, you hereby agree to notify _____ and provide _____ with a copy as soon as possible so that your physician will be able to comply with your wishes.

5). Expiration date of Advance Directive, if any _____.

(If the Advance Directive was formulated before 1991, it is "good" for only seven years, Advance Directive formulated after 1991, as "good" indefinitely, unless you change/amend/cancel the Advance Directive.)

6). I would like more information about Advance Directive. YES ____ NO ____

Patient Signature: _____Date: _____

Patient's Name: _____

HEALTH SERVICE ALLIANCE

Chino Valley Community Health Center
13193 Central Ave.
Chino, CA 91710
Phone: 909-464-9675
Fax: 909-590-3898

Montclair Community Health Center
5050 San Bernardino Street
Montclair, CA 91763
Phone: 909-281-5800
Fax: 909-281-5858

Appointment Cancellation / No Show Policy

Effective December 1, 2018, due to the high patient volumes, we are initiating a new policy for missed appointments. A charge of $25.00 will be added to your account for every appointment that you no show or fail to cancel with in 24 hours.

I understand that if I fail to call at least 24 hours prior to my scheduled appointment or if I no show, that I will be charged $25.00 for each missed appointment. In addition, that I will be responsible to pay in full for all such charges.

Patient's Signature _____ Date of Birth _____

Print Name _____ Date _____

HEALTH SERVICE ALLIANCE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

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

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:**_____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:

_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____ ☐ **Please mail records.**

Fax:_____ **Phone:**_____ ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.) **Date**

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

HEALTH SERVICE ALLIANCE (HSA)

Chino Valley Community Health Center
13193 Central Ave., Chino, 909-464-9675
Montclair Community Health Center
5050 San Bernardino St., Montclair, 909-281-5800

Consent for Telehealth Services 03262020

Telehealth is the remote treatment via the use of technology including phone (audio), texts, emails and audio-visual platforms to provide healthcare service to improve the functioning of the identified patient/client, by a licensed provider. Due to the fact that security and confidentiality of most technology cannot be absolutely guaranteed, the following guidelines have been adopted to provide safeguards for HSA patients/clients:

1. HSA will use technology that is HIPAA compliant wherever possible.
2. HSA is taking this time to notify the patient/client that while some risk to the confidentiality of the session exists by virtue of use of technology as medium for appointment, no willful/intentional disclosures or recordings are being made of the session.
    a. All previous confidentiality rules and regulations remain in place regardless of modality of treatment.
3. HSA will ensure that staff and patient/client is trained/informed on use of the technology and safe practices.
    a. The platform used for the session is agreed upon prior to the scheduled session; and all needed equipment (such as phone, computer, smart-phone, etc.s) is situated prior to scheduled session.
4. All reasonable steps will be taken to protect the privacy and confidentiality of the telehealth sessions.
    a. Patients/clients are informed that it is important to be in a quiet, private space that is free from distractions during the session.
    b. It is important to use a secure internet connection rather than a public/free WiFi.
    c. The use of any form of social media during sessions is prohibited.
5. HSA will follow all applicable regulations, laws, and community standards when it comes to the use of telehealth and the patient's/client's rights.
    a. HSA will make all reasonable efforts to verify the patient's identity at each session.
6. HSA will assess the patient's/client's ability to participate effectively with each session.
    a. The provider, may determine, that due to certain circumstances, telehealth is no longer appropriate and that sessions should resume to in-person format.
7. HSA acknowledges risks and benefits of telehealth:
    a. Risks include technical failures and lack of personal interaction and practice of in-person real time skills training;
    b. Benefits include convenience, increased access to care, and more flexible scheduling

8. HSA acknowledges possible risks and therefore requests that patients always provide an emergency/back-up phone number where they may be reached if disconnected, as well as information about their physical location.
    a. Patient will also be provided with contact information of provider in case of disconnection.
9. HSA will maintain a safety plan that includes at least one emergency contact and the closest emergency room to patient's/client's location, in the event of a crisis situation.
10. HSA will maintain a schedule of telehealth appointments. Should appointments need to changed or cancelled, a communication of such action should be made.
11. If patient is not an adult, HSA will need the permission of the parent or legal guardian (and their contact information) in order for patient/client to participate in telehealth sessions.

Signature below indicates that I have been provided the above aforementioned information, understand it, and am in agreement.

_____	_____
Patient/Client Name	Provider Name
_____ _____	_____ _____
Patient/Client Signature Date	Provider Signature Date
_____	_____ _____
Name of Legal Representative / Guardian (If patient/client is unable to consent for self)	Signature of said representative Date