MCHC HEALTH CENTERS

We respect your privacy and keep all information confidential!

The questions we ask on the Patient Registration form are important. Our providers need information about your medical and surgical history, sexual orientation, race and other personal facts to make sure they provide care that addresses your individual risk factors and needs.

If you have any questions or concerns about the questions on the Patient Registration form, please discuss them with your nurse or medical provider when roomed.

Thank you.

MCHC HEALTH CENTERS

¡Respetamos su privacidad y mantenemos toda información confidencial!

Las preguntas que hacemos en la forma de registro del paciente son importantes. Nuestros proveedores médicos necesitan información sobre su historia médica y quirúrgica, orientación sexual, raza y otros datos personales para asegurar que le proporcionen el cuidado adecuado con sus factores de riesgos individuales y sus necesidades.

Si usted tiene algunas preguntas o preocupaciones a cerca de las preguntas en la forma de registro del paciente, por favor discútalas con su enfermera o médico cuando lo atiendan.

Gracias.

MCHC HEALTH CENTERS

PATIENT REGISTRATION

Last Name:	First Name:	Middle Initial:
Previous Last Name(s):	Preferred First Name:	
Preferred Pronoun (he, she, they):	Social Security Number:	
Date of Birth:	Gender at Birth: ☐ Female ☐ Male	
Mailing Address:		
City, State, Zip:		
Physical Address:		
Phone Number: ☐ Cell ☐ Home	Ok to leave message? ☐ Yes ☐ No	
Alternate phone number: ☐ Cell ☐ Home ☐ Work ☐ Other		
E-Mail Address: ☐ No E-Mail Address		
Primary Language: ☐ English ☐ Spanish ☐ Other		
Primary Care Provider (PCP):		
Marital Status: ☐ Single ☐ Single with Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)		
Emergency Contact Name:		
Phone Number:	Relationship to Patient:	

For Patients Under 18 or Dependent Adults: Parent(s)/Legal Guardian(s)/Conservator

Name:	Relationship to Patient:	
Date of Birth:	Social Security Number:	Phone Number:
Address (if different than patient address):		
Name:	Relationship to Patient:	
Date of Birth:	Social Security Number:	Phone Number:
Address (if different than patient address):		

Additional Patient Demographic Information: This required information is for demographics purposes only

Family Size:

Household Income: ☐ Monthly ☐ Annually

Farm worker: ☐ Yes ☐ No If yes, please select type: ☐ Migrant ☐ Seasonal

Veteran: ☐ Yes ☐ No

Homeless: ☐ Yes ☐ No
If yes, please select homeless status:
- ☐ Doubling Up (Family or Friend)
- ☐ Permanent Supportive Housing
- ☐ Motel/Hotel
- ☐ Housing Program
- ☐ Street/Campground
- ☐ Transitional Housing
- ☐ Shelter

Gender Identification:
Please select one:
- ☐ Female
- ☐ Male
- ☐ Female to Male/Transgender
- ☐ Male to Female/Transgender
- ☐ Genderqueer
- ☐ Other _____
- ☐ Decline to Specify

Sexual Orientation:
Please select one:
- ☐ Heterosexual (straight)
- ☐ Homosexual (Gay, Lesbain)
- ☐ Bisexual
- ☐ Don't know
- ☐ Other _____
- ☐ Decline to Specify

Race:
Please select one:
- ☐ White
- ☐ American Indian/Alaska Native
- ☐ Black/African American
- ☐ Asian Indian
- ☐ Other Asian
- ☐ Chinese
- ☐ Korean
- ☐ Japanese
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian/Chamorro
- ☐ Filipino
- ☐ Samoan
- ☐ Decline to specify

Ethnicity:
Please select one:
- ☐ Not Hispanic, Latino(a) or Spanish Origin
- ☐ Puerto Rican
- ☐ Mexican, Mexican American, Chicano(a)
- ☐ Another Hispanic, Latino(a) or Spanish
- ☐ Cuban
- ☐ Decline to specify

Primary Insurance: ☐ Partnership/Medi-Cal ☐ Medicare ☐ CMSP ☐ Family Pact ☐ Other Insurance

ID/Subscriber Number:

Plan/Group Number:

Subscriber Name (if not self):

Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance: ☐ Partnership/Medi-Cal ☐ Medicare ☐ CMSP ☐ Family Pact ☐ Other Insurance

ID/Subscriber Number:

Plan/Group Number:

Subscriber Name (if not self):

Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

CONDITIONS OF TREATMENT

FINANCIAL AGREEMENT: I agree to make prompt payments as bills are received for services rendered by Mendocino Community Health Clinic, Inc. I agree to pay interest at the legal rate if the account becomes delinquent, and if it becomes necessary for the account to be referred to collection, I will pay the attorney's fees and collection expenses.

If you are concerned about your ability to pay for your medical care please speak with our Financial Services Representatives.

MEDICARE ASSIGNMENT: I certify that the information given by me in applying for payment under Title VII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF INSURANCE BENEFITS: In the event I am entitled to benefits from any insurance policy insuring me or any party liable to me, I assign those benefits directly to MCHC, Inc. for application to my bill. I agree that MCHC, Inc., may issue a receipt for such payment, that such payment will discharge the insurance company of obligations under the policy to the extent of the payment, and that I shall be responsible for charges not covered by this agreement.

GENERAL CONSENT TO TREATMENT: By signing below, I authorize MCHC staff and healthcare providers to perform any examination, tests and procedures and to provide any medications, treatment or therapy necessary to assess, diagnose and treat me. I understand that I may still refuse any particular examination, test, procedure, treatment, therapy or medication. I may also be asked to sign additional forms giving consent to specific types of treatments or procedures. I also understand that the practice of medicine is not an exact science and that no guarantees can be made to me as to the results of my evaluation and/or treatment.

Patient Signature: _____

(Parent or guardian must sign for minors)

Print Name: _____ Date: _____

Witness Signature: _____

INFORMATION: ADVANCE DIRECTIVES
AND DO NOT RESUSCITATE ORDERS

What is an advance directive?	An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives. A good advance directive describes the kind of treatment you would want for different levels of illness. For example, the directives would describe what kind of care you want if you have a critical illness, a terminal illness or permanent unconsciousness. Advance directives usually tell your doctor that you don't want certain kinds of treatment. However, they can also say that you want a certain treatment no matter how ill you are. Advance directives can take many forms. Laws about advance directives vary from state to state. You should be aware of your state laws regarding the scope and requirements that apply to advance directives.
What is a living will?	A living will is one type of advance directive. It only comes into effect when you are terminally ill. Being terminally ill generally means that you have less than six months to live. In a living will, you can describe the kind of treatment you want in certain situations. A living will doesn't let you select someone to make decisions for you.
What is a durable power of attorney	A durable power of attorney (DPA) for health care is like a living will, but it becomes active any time you are unconscious or unable to make medical decisions. In a DPA, you select a family member or friend who will be your medical decision-maker if you become unconscious or unable to make medical decisions. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you. Living wills and DPA's are legal in most states. Even if they aren't officially recognized by the law in your state, they can still guide your loved ones and doctor if you are unable to make decisions about your medical care. Ask your doctor, lawyer or state representative about the law in your state.
What is a do not resuscitate order?	A do not resuscitate (DNR) order is a request not to have cardio-pulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instruction, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states. Most patients who die in a hospital have had a DNR order written for them. Patients who are not likely to benefit from CPR include people who have cancer that has spread, people whose kidneys don't work well, people who need a lot of help with daily activities, or people who have severe infections such as pneumonia that require hospitalization. If you already have one or more of these conditions, you should discuss your wishes about CPR with your doctor, whether in the doctor's office or when you go to the hospital. It's best to do this early, before you are very sick and are considered unable to make your own decisions.

Should I have an advance directive?	Most advance directives are written by older or seriously ill people. For example, someone with terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase her peace of mind and increase her control over her death. You might want to consider writing an advance directive even if you are in good health. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.
How can I write an advance directive?	You can write an advance directive in several ways: • Use a form provided by your doctor. • Write your wishes down by yourself. • Call your state senator or state representative to get a form. • Call a lawyer • Use a computer software package for legal documents. Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. The orders should be notarized if possible, and copies should be given to your family and your doctor.
Can I change my advance directive?	You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them. If you do not have time to put your changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

From The American Academy of Family Physicians

Acknowledgement of Receipt of Privacy Practices

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Mendocino Community Health Clinic. Our *Notice of Privacy Practices* tells you how we may use and disclose your protected health information. We encourage you to read it in full.

We may change our *Notice of Privacy Practices*. If we change our notice, you may obtain a copy of the revised notice by accessing our website: http://www.mchcinc.org/ by going to the Patient Privacy link at the bottom of the page, or pick up a paper copy at any MCHC lobby. In addition, each time you register at or come to MCHC for treatment or health care services, a copy of the current notice in effect will be available to you.

If you have any questions about our *Notice of Privacy Practices*, please contact:

ADDRESS:	MCHC Privacy Officer 333 Laws Avenue Ukiah CA 95482.
PHONE:	(707) 472-0218

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

____ I have read and understand this notice

-OR-

____ I have read and decline to sign this notice

I acknowledge receipt of Mendocino Community Health Clinic's *Notice of Privacy Practices.*

Signature: _____ Date: _____

Patient/Legal Representative