Valle Verde Medical Group

PATIENT INFORMATION

Last Name:________________ First Name:________________ Middle Name:________________

Birth/Maiden Name________________ Gender: Female Male Driver's License Number:________________

Social Security:________________ Marital Status________________ Date of Birth:________________

Race:________________ Ethnic Group________________ Language:________________

Home Address:________________ City:________________ ________________

State:________________ Zip Code:________________ Country:________________

Home Phone #:________________ Cellular #:________________ Work #:________________

Preferred Contact Method:________________ Preferred Reminder Method:________________

Patient's Employer________________ Occupation:________________

Allergies:________________ Mother's Name:________________

In case of Emergency, who should we notify?________________

Relationship to Patient________________ Phone:________________

PRIMARY INSURANCE COMPANY:________________ Effective Date:________________

Policy #:________________ Group #:________________ Social Security # :________________

Name of Insured:________________ Date of Birth: ________________ Relationship to Patient:________

SECONDRY INSURANCE COMPANY:________________ Effective Date:________________

CONSENT FOR MEDICAL TREATMENT OF A CHILD

I make an oath and say that I am the parent/lawful guardian of the child listed above and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person. I here consent to my child's medical examination or treatment. Such treatment may include but is not limited to the following: medical examination, diagnoses, medication, immunizations, x-rays, lab work, local anesthesia , transportation by ambulance, hospitalization. This consent will remain in effect until it is revoked by notifying my child's medical health care provider in writing.

ASSIGNMENT AND RELEASE

I, the undersigned, have the insurance listed above and directly assign Valle Verde Medical Group all medical benefits. If the insurance does not cover I agree to pay for the services rendered to me or my dependents. I hereby authorize the doctor to release information to secure payment of benefits. I authorize the use of my signature on all my insurance claim forms whether sent by mail or electronically.

Patient's/Parent's/Guardian's Signature:________________ Date:________________

VALLE VERDE MEDICALGROUP

Advance Health Care Directive

Required for ALL patients 18 years of age and older, and all emancipated minors.

I ______________________________ have been given information about Advance Health Care Directive.
Patient's Name

☐ **I do have** an Advance Health Care Directive and **will provide** a copy to my doctor on__________________________.

☐ **I do not have** an Advance Health Care Directive and I **wish to complete one** at this time.

☐ **I do not have** an Advance Health Care Directive and **I do not wish to complete** one at this time.

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Directiva Anticipada de Atención De Salud

Se requiere para todos los pacientes de 18 años o más y menores emancipados

Yo ______________________________ he recibido información acerca de Directiva Avanzada de Cuidado de Salud.
Nombre del paciente

☐ **Yo tengo una** Directiva Avanzada de Cuidado de Salud y le **voy a dar una copia a mi doctor en** __________________________.

☐ Yo **no tengo** una Directiva Avanzada de Cuidado de Salud y **deseó completar una hoy**.

☐ Yo **no tengo una** Directiva Avanzada de Cuidado de Salud y **no deseo completar** una hoy.

Patient's Signature:
Firma del Paciente: __________________________ Date of Birth
Fecha de Nacimiento:__________

Signature of person explaining information to patient:__________________________

Printed Name:__________________________ Date:__________________

Comments:____

Valle Verde Medical Group

OPTIONAL

Authorization to Release Personal Information

Patient's Name: ______________________________ DOB: ___________

To Whom It May Concern:

I authorize ____ to pick-up medical records from your office containing personal information. I'm aware that I need to sign the Medical Records Request first. He/she is also authorized to schedule/re-schedule my appointments, pick-up my prescriptions disability, lab and X-ray referrals.

Initials ______ I authorize release of information regarding my account to the person listed above.

Patient's Signature:____________________________________ Date:___________

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Consent for Minor Medical Care (Optional)

Initials ______ I authorize ____________________________________ to take my child to the doctor and have the person listed above sign authorization to provide medical care including immunizations and injections that my child might need.

Parent/Legal Guardian's Signature: ___________________________ Date:________

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (831) 754-1544.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices and have authorized the methods of communication as listed below:

Authorized Method of communication (Check all that apply)

	Residence Telephone ( )________		Cell Phone ( )________		Work Telephone ( )________	Written Correspondence Mail/Delivery Service
	Leave call back number only; do not leave a message		Leave call back number only; do not leave a message		Leave call back number only; do not leave a message	Fax ( )________
	Okay to leave a detailed message with person answering the phone		Okay to leave a detailed message on personal voice mail		Okay to leave detailed message with operator	e-mail ________ ________
	Okay to leave a detailed message on the answering machine				Okay to leave a detailed message on personal voice mail	

Print Name :________________ Signature:________________

Date of Birth :________________ Date:________________

HEALTH INFORMATION EXCHANGES / PATIENT PORTALS

We use and share your health information with your doctors/providers involved in your care through the Central Coast Health Connect, a Health Information Exchange (HIE) and the SVMHS patient portal using a secure internet connection. An HIE is a way of sharing health information with other participating health care providers or entities for treatment, payment and health care operation purposes. This allows your participating health care provider to have your most recent information available from other participating health care providers when making decisions about your care. You may opt-out and prevent your medical information from being available through the Central Coast Health Connect, or prevent the sharing of your health information by e-mailing the CCHC help desk at cchc-help@centralcoasathealthconnect.org or calling (831) 644-7494.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: For Treatment, For Payment, For Health Care Operations, Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services, Individuals Involved in Your Care or Payment for Your Care

***SPECIAL SITUATIONS:**

*As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

*To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to our health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

*Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

*Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to indentify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstance, we are unable to obtain the person's agreement; (4) about a death we believe may be the results of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

*Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits to work-related injuries or illness.

*Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authorities if you are a member of a foreign military.

*Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with product; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

*Research * Business Associates *Organ and tissue Donation
*Health Oversight Activities *Data Breach Notification Purposes

Your Guide to Understanding Central Coast Health Connect

A Health Information Exchange for Monterey County

What is Central Coast Health Connect (CCHC)?

CCHC is a community health information exchange (HIE), a system established to help [illegible] and healthcare providers securely share health [illegible] electronically. An HIE helps to ensure that [illegible] you and the caregivers you authorize — including [illegible], hospitals, and labs — have secure, instant [illegible] vital medical information necessary to provide [illegible] best care possible.

Why is it important [illegible] participate in CCHC?

Many people see [illegible] care providers, often in separate locations. The [illegible] about their care, such as doctors' office visits, [illegible], lab tests, and imaging historically has also [illegible] can lead to unnecess[illegible] increased safety risks. [illegible] collaboration, leading [illegible] organizations are [illegible] health information [illegible] to link patients and [illegible] care providers. When you and your healthcare providers participate in CCHC, your healthcare team can securely access and share pertinent medical information, enhanc[illegible] the ability to make the best decisions for your care.

How is my information secure?

Protecting privacy is a top priority in the CCHC [illegible]. Access to patient data is strictly [illegible] and federal privacy laws require policies [illegible] followed and enforced. CCHC [illegible] patient privacy is essential, and we make [illegible] to ensure patient data is securely managed.

Can I get my test results electronically with CCHC?

Yes. A major benefit to patients is the CCHC patient portal. If you provide your email address when you register — depending on the services you receive — you will get an email invitation to join the CCHC patient portal. If you receive an invitation, please click the 'register' link within the email and follow the instructions to create your account. (Currently, CCHC does not allow dependent or minor patient portal accounts). Within four [illegible] following your visit, you will receive any (non-[illegible]) test results or related health data.

What if I [illegible] participate in CCHC?

If you don't [illegible] in CCHC, you may choose [illegible] important to understand that [illegible] sharing of your information [illegible] providers. If they choose, your [illegible] will still be able to individually [illegible] exchange to have your [illegible], and other data sent directly [illegible] may have received this information [illegible] communication. If you still choose to opt out, [illegible] email:

cchc-help@[illegible]thconnect.org
or call (831) 644-[illegible]

To learn more about [illegible] Coast Health Connect, please call (831) [illegible] or visit: centralcoasthe[illegible].org

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State and federal laws regarding [illegible] electronic distribution of *sensitive* test results prevents us from providing you with all of your test results through the CCHC patient portal. For additional information about those results considered sensitive, please refer to California State Health and Safety Code 123148, particularly the following section:

"... none of the following clinical laboratory test results and any other related results shall be disclosed to a patient by internet posting or other electronic means:

(1) HIV antibody test

(2) Presence of antigens indicating a hepatitis infection

(3) Abusing the use of drugs

(4) Test results related to routinely processed tissues, including skin biopsies, Pap smear tests, products of conception, and bone marrow aspirations for morphological evaluation, if they reveal a malignancy."

CCHC
CENTRAL COAST HEALTH CONNECT