Valley-Wide Health Systems, Inc.

PATIENT INFORMATION

_____

(Last) (First) (M.I)

_____

(Birth Date) Sex: Male ◯ Female ◯

_____

Billing Address City

_____

State Zip

_____

Secondary Address City

_____

State Zip

(____)_____(_____)_____

Primary Phone Secondary Phone

_____

E-mail Address

_____(_____)_____

Emergency contact name Phone

_____(_____)_____

Guarantor (person responsible for payment) Phone

_____

Guarantor Address

Preferred Language _____

Homeless Yes ◯ No ◯

Do you reside in public housing Yes ◯ No ◯

Race

White ◯ Asian ◯
Black/ African American ◯
Other ◯ Refused ◯
Unknown ◯

Ethnicity

Hispanic or Latino ◯
Not Hispanic or Latino ◯
Other ◯ Refused ◯
Unknown◯

MEDICAL INFORMATION

Primary Medical Provider:_____

Primary Dental Provider:_____

Medical Insurance Name:_____

Policy Number:_____

Group Number:_____

Would you be willing to provide the following information?

Yes ◯ No ◯

Family Size_____ Monthly income $_____

Why do we ask? We are a federally Qualified Healthcare Center (FQHC). Our federal funding that we receive to enhance our services is based off these numbers.

Are you or a family member a agricultural worker?_____

In the last 24 months have you or a member of your family

Been hired to do agricultural (Ag) work ? Yes ◯ No ◯

Is the majority of your income from Ag work ? Yes ◯ No ◯

Moved temporarily to do Ag work? Yes ◯ No ◯

Have you stopped working in Ag due to age or disability? Yes ◯ No ◯

Consent to Treat and Authorization to Pay Benefits to Valley-Wide Health Systems, Inc.

Valley-Wide Health Systems, Inc. (VWHS), provides treatment and care through an integrated model. VWHS provides whole person care by a care team which, in our system, includes various aspects of physical health, behavioral/mental health, and support services.

I consent to treatment and care by Valley-Wide Health Systems Inc. I understand that treatment and care in an integrated model may include any or all routine health maintenance services (including immunizations, screeners, introduction to other service providers in our system, and/or external referrals) for acute and chronic health conditions depending on my condition. These services may include any of the following departments: medical, dental, physical therapy, behavioral/mental health and pharmacy.

I understand that the services authorized by this consent include those provided under the auspices of VWHS by physicians, nurse practitioners, physician assistants, medical technologists, behavioral/mental health providers, physical therapists, physical therapist assistants, dentists, dental hygienists, dental assistants, nurses, health educators, medical assistants, and pharmacists. I understand that my care team may include health professionals-in-training under the supervision of a licensed and responsible health professional practicing within the scope of their education, training and certification.

I understand that I have the right to refuse any or all services in any combination, or by any member of the treatment team. I understand I have the right to discuss any treatment plan with my care team about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommend by my care team, I am encouraged to ask questions.

I also understand that my medical records for all services described above are maintained within a single location and may be shared across each service line described above. These records are to be kept confidential and the release of any health information is protected under and will conform to law under the HIPAA Privacy Rule.

I hereby authorize payment directly to Valley-Wide Health Systems, Inc. for healthcare benefits. I understand that I am financially responsible to Valley-Wide Health Systems, Inc. for services not paid by insurance or other third party payors. I understand that if I have been issued a refund check and I fail to cash a refund check or the refund check is returned as undeliverable after reasonable attempts to contact have been unsuccessful, such check will be considered a donation to VWHS.

Signature of Patient:_____ Date:_____

If patient is over 18, GUARDIAN (if patient is under age 18) or WITNESS (if adult patient is unable to sign)