FHCCGLA
Family Health Care Centers of Greater Los Angeles, Inc.

FOR OFFICE STAFF ONLY

CORA Status: ☐ Yes ☐ No	**FHCCGLA Envelope:** ☐ Yes ☐ No
Clinic Site: ☐ Bell Gardens Family Medical Center ☐ Hawaiian Gardens Health Center ☐ Downey Family Medical Center ☐ Maywood Family Medical Center ☐ School Based Health Center	Medical Record #:
	Relationship to Responsible Party: ☐Self ☐Child ☐Spouse ☐Other: _____
HIPPA Handout Given: Date: ____/____/____ Initials: _____	Advanced Directive Given: Date: ____/____/____ Initials: _____

PATIENT INFORMATION		RESPONSIBLE PARTY *(Enter name of person who is financially responsible for your account)*	
Patient Last Name: Patients First Name:		Responsible Party Last Name/First Name: Relationship:	
Social Security Number:	Date of Birth: (MM/DD/YYYY)	Social Security Number:	Date of Birth: (MM/DD/YYYY)
Address:		Address:	
City:	State: Zip Code:	City:	State: Zip Code:
Mothers Maiden Name:	Place of Birth:	Mothers Maiden Name:	Place of Birth:
Are you: [ ] Employed [ ] Unemployed [ ] Student [ ] Retired Select one: [ ] Full-Time [ ] Part-time		Are you: [ ] Employed [ ] Unemployed [ ] Student [ ] Retired Select one: [ ] Full-Time [ ] Part-time	
Monthly Income Type (Check, Cash, Etc.) _____ Monthly Income Amount: $_____	Family Size: #: _____	Monthly Income Type (Check, Cash, Etc.) _____ Monthly Income Amount: $_____	Family Size: #: _____
Agricultural Worker: [ ] Seasonal [ ] Migrant Worker	Homeless: [ ] Yes [ ] No [ ] Doubling Up [ ] Street [ ] Transitional [ ] Homeless Shelter [ ] Other: _____	Agricultural Worker: [ ] Seasonal [ ] Migrant Worker	Homeless: [ ] Yes [ ] No [ ] Doubling Up [ ] Street [ ] Transitional [ ] Homeless Shelter [ ] Other: _____
Phone Number: [ ] Home [ ] Cell [ ] Work		Phone Number: [ ] Home [ ] Cell [ ] Work	
UDS Data Required: *Please provide the following confidential information.* **Birth Sex:** [ ] Male [ ] Female **Current Gender:** [ ] Male [ ] Female **Gender Identity:** [ ] Male [ ] Female [ ] Transgender Male-to-Female [ ] Transgender Female-to-Male [ ] Choose not to disclose **Sexual Orientation:** [ ] Straight/Heterosexual [ ] Gay/Lesbian/Homosexual [ ] Bi-sexual [ ] Choose not to disclose		UDS Data Required: *Please provide the following confidential information.* **Birth Sex:** [ ] Male [ ] Female **Current Gender:** [ ] Male [ ] Female **Gender Identity:** [ ] Male [ ] Female [ ] Transgender Male-to-Female [ ] Transgender Female-to-Male [ ] Choose not to disclose **Sexual Orientation:** [ ] Straight/Heterosexual [ ] Gay/Lesbian/Homosexual [ ] Bi-sexual [ ] Choose not to disclose	
Marital Status: [ ] Single [ ] Married [ ] Other	Military Status [ ] Non-Military [ ] Veteran/Retired [ ] Active Duty/Branch _____	Marital Status: [ ] Single [ ] Married [ ] Other	Military Status [ ] Non-Military [ ] Veteran/Retired [ ] Active Duty/Branch _____
Ethnicity – Do you consider yourself to be Hispanic / Latino? [ ] Yes [ ] No		Ethnicity – Do you consider yourself to be Hispanic / Latino? [ ] Yes [ ] No	
Race: Which group do you identify yourself as being part of? (check all that apply) [ ] Asian [ ] Native Hawaiian/Other Pacific Islander [ ] Black/African American [ ] Decline to State [ ] American Indian/Alaska Native [ ] White [ ] More than one race		Race: Which group do you identify yourself as being part of? (check all that apply) [ ] Asian [ ] Native Hawaiian/Other Pacific Islander [ ] Black/African American [ ] Decline to State [ ] American Indian/Alaska Native [ ] White [ ] More than one race	
Email Address: (for appointment reminders & Patient Portal enrollment)		Email Address: (for appointment reminders & Patient Portal enrollment)	
Preferred Language: _____ Interpreter Services: [ ] Yes [ ] No		Preferred Language: _____ Interpreter Services: [ ] Yes [ ] No	

EMERGENCY CONTACT (REQUIRED)			
First Name:	Last Name:	Relationship to Patient:	Gender:
Address:	City:	State:	Zip Code:
Home Phone Number ( )	Work Phone Number ( )	Cell Phone Number ( )	

I have provided all above information willingly and I authorize the release of any medical information necessary to process medical claims and authorize payment of medical benefits to Family Health Care Centers of Greater Los Angeles, Inc. I agree to pay any balance of professional service charges that exceed insurance payment.

Signature: _____ **Date:** _____

(Patient, Parent, Legal Guardian, or Authorized Person)

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PEDIATRIC GENERAL CONSENT FOR TREATMENT

Family Health Care Centers of Greater Los Angeles, Inc. (FHCCGLA) offers primary health care in an ambulatory clinic setting. Our focus is preventive health services that are preventive in nature, including pediatric services, prenatal care, family planning, breast and cervical cancer screening, treatment of certain sexually transmitted diseases and other services such as Behavioral Health, Dental and Optometry (available at our Bell Gardens Family Medical Center site). FHCCGLA's clinics provide pediatric health care services, which is preventative in nature, including well baby care, immunizations, child health screening, and adolescent care, with limited acute care services. A referral service is provided for clients whose concern is not within the scope of practice defined by FHCCGLA.

FHCCGLA clinics, Bell Gardens Family Medical Center (BGFMC), Maywood Family Medical Center (MFMC), Hawaiian Gardens Health Center (HGHC), Downey Family Medical Center (DFMC) and the School Based Health Center (SBHC) participate in health care subsidized programs offered by the federal, state, and county government and managed care programs. As a condition of these programs, client's charts are reviewed and evaluated for quality and program compliance. However, information regarding a single client requires the notification and consent of the client for release unless requested by court subpoena.

- I understand that I have the right to be treated with dignity and respect.
- I understand that I will receive explanation to any questions regarding my child, have privacy and confidentiality of my child's records and have the ability to review my child's records with a clinician.
- I understand that I have the right to refuse any care of treatment for my child at any time.
- I understand that I am responsible to follow health advice for my child, medical instructions, to also be honest regarding my child's medical history, and to report any significant changes in my child's health to the clinic.
- I have the right to make a complaint on behalf of my child about treatment or events that take place within the clinic. I have the right to have a fair hearing regarding such complaints. A procedure for such hearing will be explained to me.

Under the conditions stated, I consent to the examination and laboratory test considered necessary for my child's health and to the confidential release of my medical records for FHCCGLA.

Authorization is effective immediately and is to continue in effect until withdrawn in writing.

Signature: _____ Date: _____
(Parent or Guardian)

Witness: _____

Patient Name: _____ D.O.B: _____ Chart# _____

CONSENT FOR
SHARING OF COMPUTERIZED IMMUNIZATION RECORDS WITH PROVIDERS AND CERTAIN AGENCIES

This clinic is maintaining a computerized record of your/your child's immunizations records, which includes the vaccines and the dates they were given. This will allow us to better track and serve his/her health needs.

We will update the immunization record and share this information with a Central Immunization Registry for Los Angeles County. Other doctors, clinics, or hospitals will be able to check the Immunization Registry to see what immunizations you/your child has had. Public and private schools will also be able to check the Immunization Registry to be sure your child has all the shots needed for school. Immunization information will also be shared with the WIC (Women, Infants, and Children) Program if you are a participant so they can help you make sure your child is up-to-date with all immunizations.

Only the following information will be shared with these providers/agencies:

- patient name,
- date of birth,
- current address and phone number,
- mother's maiden name
- immunizations received and dates,
- medical provider that gave immunization

This clinic and all other participating doctors' offices, clinics, hospitals, schools, and WIC programs will keep this information confidential. They will not share it with any other person or agency. They will use it only to help you and your child receive the proper immunizations and remind you when immunizations are due.

You may refuse to let your information be shared with the Central Immunization Registry, and other providers and agencies who may care for you or your child. (See below)

CONSENT

I understand that by signing this consent I am giving permission for my/my child's immunization record to be shared with:

- *a Central Immunization Registry (Data Bank),*
- *other doctors, clinics, or hospitals that may provide care to me/my child,*
- *public and private schools and the WIC Program if it applies to me.*

Patient Name: _____ Date of Birth _____

_____ _____

Signature (Parent/Legal Guardian) Date

This consent will remain in effect for any current or future immunization records unless written notification to withdraw consent is received.

REFUSAL

PLEASE NOTE: Refusal to participate in the Los Angeles County Computerized Immunization Registry will result in the inability of any other provider (doctor, clinic, hospital, emergency room) that your child may attend to access your child's updated computerized immunization record maintained at this clinic.

I refuse to permit my child's immunization record be shared with other doctors, clinics, hospitals, schools and the WIC program.

Patient Name: _____ Date of Birth: _____

_____ _____

Signature (Parent/Legal Guardian) Date:

This refusal will be remain in effect for any current of future immunization records unless the participating medical doctor, health clinic, or immunization clinic that obtained this refusal receivers a written notification to withdraw the refusal.

CHART #

FHCCGLA
Family Health Care Centers of Greater Los Angeles, Inc.
"A Legacy of Compassionate Service to All"

Notice of Privacy Practices

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Practices identifies: 1) how medical information about you may used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that she/he has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____
Name of Patient Signature of Patient

_____/_____/_____
Date Signed

_____ _____
Name of Patient's Personal Representative Signature of Patient's Personal Representative

_____/_____/_____
Date Signed

FOR INTERNAL USE ONLY

_____ _____
Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained

- ☐ Patient was unable to sign
- ☐ Patient refused to sign
- ☐ Other _____

_____

Notice of Privacy Practices (NPP)
Acknowledgment

____/____/____ (Date as noted on NPP)

FHCCGLA
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NOTICE OF PRIVACY PRACTICES

This notice describes how *Protected Health Information (PHI)* about you may be used and disclosed and how you can get access to this information. The confidentiality extends to all methods of communication which includes, written, electronic, verbal, or other.

USES & DISCLOSURES

Treatment: Your PHI may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your PHI may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, workers' compensation carrier, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your PHI may be used as necessary to support the day-to-day activities and management of the *Family Health Care Centers of Greater Los Angeles, Inc.* For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Your health information may also be disclosed to doctors, nurses, technicians, medical students, and other health care personnel for review and learning purposes.

Legal Requirements: We will disclose PHI about you when required to do so by federal, state or local law, including workers' compensation laws. We also share PHI when required by a court of law, or when required by law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

Public Health Reporting: Your PHI may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to state or county public health departments.

Additional Uses of Information: Appointment reminders. Your PHI will be used by our staff members to send or call you regarding appointment reminders.

Information About Treatment: Your PHI may be used to send you information on the treatment and management of your medical condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. Research projects are subject to a special approval process. Before we disclose medical information for research, the project will have been approved through this research

approval process. We may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who are you.

Other Uses and Disclosures Require Your Authorization: Disclosure of your health information or its uses for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

RIGHTS & RESPONSIBILITIES

Individual Rights: You have certain rights under the federal privacy standards these include:

- The right to request restrictions on the use and disclosure of your protected health information.*
- The right to receive confidential communications concerning your medical condition and treatment.*
- The right to inspect and copy your protected health information.*
- The right to amend or submit corrections to your protected health information.*
- The right to receive an accounting of how and to whom your protected health information has been disclosed.*
- The right to receive a printed copy of this notice.

* *Certain restrictions may apply.*

Family Health Care Centers of Greater Los Angeles, Inc. **Duties**: We are required by law to maintain the privacy of your PHI and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practice: As permitted by law, we reserve the right to amend or modify our privacy practices. We will provide you with a revised notice or you may obtain a copy of the revised notice by sending a request to our Privacy Officer or calling our office.

Complaints: If you would like to submit a comment or complaint about our privacy practice, you can do so, without fear of retaliation, by sending a letter outlining your concerns to our Privacy Officer or contacting the U.S. Dept of Health & Human Services-Office for Civil Rights:

Sophia N. Chun, M.D.
Interim C.M.O.
6501 S. Garfield Avenue
Bell Gardens, CA 90201
(562) 928-9600

Office for Civil Rights
U.S. Dept. Of Health & Human Services
200 Independence Ave., S.W.
Room 509F, HHH Bldg.
Washington, D.C. 20201
(800) 368-1019

Your Information. Your Rights. Our Responsibilities

When it comes to your health information, you have certain rights.

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this
- We will provide a copy of a summary of your health and claims records, usually within 30 days of your request. WE may charge a reasonable, cost-based fee.
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we share it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
- You can complain if you feel we have violated your rights by contacting us at 562-928-9600
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filling a complaint.

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

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Patient Text Messaging Consent Form

To remind patients of their healthcare appointment, and to reduce the number of missed appointments, we have introduced a new system; CareMessage.

You can now be sent an appointment reminder by text message to a mobile phone. In addition, a text message will be sent related to your healthcare (i.e. referrals, pap smears, and clinical breast exam, etc.).

If you choose to be reminded by text message, you have an option to stop text messages at anytime. Simply contact us at 562-928-9600, press 1, and then press 1 again.

If you accept to be reminded about your appointment by text message, please complete the information below:

I authorize Family Health Care Centers of Greater Los Angeles, Inc. (FHCCGLA) to remind me by text message of any future appointments, or health promotions.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all occasions and that the responsibility of attending appointments or cancelling them still rests with me.

I understand that my mobile number will not be used for any other reason.

I understand that if my mobile number changes or is no longer in my possession it is my responsibility to notify FHCCGLA.

I understand that I have the option to stop reminders by text message at any time.

Mobile Number: (_____) _____ - _____

Name: _____

Signature: _____

Date: _____/_____/_____

D.O.B.:____/____/____ Chart#_____

Revised 10-14-16RRV

FHCCGLA
Family Health Care Centers of Greater Los Angeles, Inc.

Common Questions and Answers

Q: ***I would like the text message to include the name of my provider or the department that my appointment is with. Is this possible?***

A: Unfortunately this is not possible. Due to patient confidentiality, we are unable to enter this information. This is due to the possibility that a patient may have their mobile phone text messages viewed by a friend or family member, and they may wish to keep their appointment confidential.

Q: ***This service is only available to those who have a mobile phone and use the text messaging function on their phone. Can you expand this service to telephone (landlines) and email?***

A: Currently, we are only able to offer this service through text messaging to a mobile phone. We are unable to offer an automated service for email at the moment. However, please ensure to provide us with your email address just in case that we begin to utilize this method in the future.

Q: ***Is there a charge to me for this service?***

A: We do not charge you for this service.

Q: ***Will my contact details be kept confidential?***

A: Patient Confidentiality is governed under the Data Protection Act. Your information will be stored onto our system and will be able to be accessed by our organization only as part of your patient record. It will not be disclosed to any outside agency other than as permitted by law.

Q: ***What happens if I change my mobile phone number?***

A: Please tell us as soon as possible by calling 562-928-9600 and the phone operator will update the system and add your new number to allow you to continue to receive reminders to your new number.

Q: ***What if I don't wish to receive reminders anymore?***

A: All you need to do is call 562-928-9600 and notify the phone operator and they will update the system to reflect that you no longer wish to receive text message reminders.

FHCCGLA
Family Health Care Centers of Greater Los Angeles, Inc.

Attention: _____
Medical Records Dept.

Release of Records and/or Disclosure
AUTHORIZATION

Patient Name: _____ Chart #: _____ D.O.B. ____/____/____

I hereby request my medical record to be released to: ☐ Agency Named Below ☐ Myself

To: _____	**From:** _____
Address: _____	**Address:** _____
City: _____	**City:** _____
Phone: _____	**Phone:** _____
Fax: _____	**Fax:** _____

Records: ☐ Medical Information ☐ H.I.V. Test Results ☐ Lab Results ☐ Dental X-Rays
☐ Other (Please Specify): _____

Duration: This authorization shall become effective from the date signed and will remain in effect until ____/____/____ or for one year from the date of signature, if no date entered.

Revocation: I understand that this authorization is subject to written revocation (withdrawn) by me at anytime.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information provided unless another authorization is obtained from me or unless disclosure is explicitly required/permitted by law.

☐ **I agree to pay a $20.00 processing fee for a copy of my Medical Records.**

☐ **I agree to pay a $5.00 processing fee for a copy of my Dental X-Rays.**

I request that the health information released pursuant to this authorization be used for the following purpose only:

Continuity of Care

I hereby authorize the medical providers and/or employees of Family Health Care Centers of Greater Los Angeles, Inc. to release the medical information as indicated. I am aware that a copy of this authorization is also valid as an original and that I have a right to obtain a copy of this authorization for me to keep.

_____ **Date:** _____
Patient/Legal Guardian's Signature

_____
Relationship (if signed by other than patient)

FHCCGLA
Family Health Care Centers of Greater Los Angeles, Inc.

ELIGIBILITY SCREENING STATUS FORM

Date: ___/___/_____ Initial's:_____ ☐ First Visit / ☐ Renewal

All patients must be screened during their initial visit and annually thereafter for eligibility. A copy of the below listed documents are required to be in the patients file.

☐ **Income Verification** - (examples: Pay stubs, Income Tax Form, Disability Benefits, Workers Comp. Income, Self-employment letter). ☐ PATIENT HAS INSURANCE DECLINES TO PROVIDE PROOF OF INCOME.

☐ **Address Verification** - (examples: Any type of letter or bill received by mail to the patient's address. Must indicate the patients name or guardian's name).

☐ **P hoto Identification** - (examples: California Driver's License, California I.D., Alien Registration Card, Student I.D., Credit Card with photo I.D.).

If the patient does not provide all of the above eligibility documents at the time of Eligibility Screening, the patient MUST bring in the missing documents during their next scheduled clinic visit.

Eligibility Status		
☐	Patient was referred to apply for Medi-Cal or Emergency Medi-Cal	Date Referred: ___/___/____
☐	Patient is NOT eligible for any other program. Patient qualifies for F.F.S. ONLY at this time. Reason: _____ _____	Expiration Date: ___/___/____
*(**DO NOT** sign or date unless Eligibility Screening is determined)*		
Eligibility Screening Completed By: _____ Staff Verification & Signature		Date: ___/___/____

☐ **Patient has been informed verbally of our agency's sliding fee discount and schedule of fees to cover the cost of all services for all eligible low-income patients.**

Patient Signature: _____ **Date:** ___/___/____

Patient's Name: _____ D.O.B.: _____ Ch.#: _____

Revised 11-17-14RRV

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24/7 secure online access from any computer, smartphone or tablet!

Sign up for our Patient Portal!

INSTANT ACCESS

Whenever you want, wherever you are. *

Appointments
Request and keep track of appointments

Lab Results
View selected tests and lab results

Medication
Request prescription refills

Medical Records
Access summary of personal service history

Messages
Send and receive messages from healthcare providers

Reminders
Receive health reminders on services needed

Demographic Information
Update contact information

Referrals
View and request status of existing referrals

Accounts
Set up family joint accounts for children/dependents and manage your entire family's healthcare in one spot.

OBTAIN ACCESS TO YOUR MEDICAL INFORMATION *ONLINE*

We will be happy to help you get started.

Gain access to your personal health record by simply, calling our office or stopping by and providing us with a personal email address.

Once you are set up with a username and password, you can gain access to your health information by using any computer or smartphone with internet connection.

You can access your records by logging into: http://nextmd.com

FOR FURTHER ASSISTANCE CALL OUR OUTREACH DEPT.
at 562-928-9600
Press 1 for English and then 2 again to speak with a representative