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Patient Registration Form

PATIENT INFORMATION *

Last Name:	First Name:	MI:	Date of Birth:	Social Security Number:

Street Address:	City:	State:	Zip Code:	County:

CONTACT INFORMATION *

Mobile Phone Number:	Home Phone Number:	Employer:	Employer Phone Number:

BACHC may contact me for clinical/appointment reminders by using the following methods (check all that apply): □ Email □ Home □ Cell □ Text (Standard data/messaging rates may apply)

Email:

Referred to clinic by (please check one): □ Dr □ Insurance Plan □ Hospital □ Family □ Friend □ Outreach □ Social Media □ Other:_____

Emergency Contact Name:	Relationship:	Emergency Contact Phone Number:

PATIENT DEMOGRAPHICS *

Primary Language Spoken:
□ English □ Spanish □ Other:_____

Would you like an interpreter?
□ Yes □ No

Race (Check all that apply):
□ Asian □ Black/African American □ White □ Central American Indian
□ American Indian/Native Alaskan □ Pacific Islander □ Native Hawaiian
□ More than one race
□ Other: _____

Ethnicity:
□ Hispanic/ Latino
□ Non-Hispanic/ Latino

Gender Identity:
□ Male
□ Female
□ Female-to-Male/Transgender Male
□ Male-to-Female/Transgender Female
□ Other
□ Choose not to disclose

Sexual Orientation:
□ Straight or heterosexual
□ Lesbian, gay, or homosexual
□ Bisexual
□ Something else
□ Don't know
□ Choose not to disclose

Marital Status:
□ Single
□ Married
□ Divorced
□ Widowed

Student:
□ Full-Time
□ Part-Time
□ Not a student

Employment Status:
□ Full-Time
□ Part-Time
□ Not Employed
□ Retired

Housing Status: Are you Homeless? □ Yes □ No
If homeless, are you:
□ Doubling up □ Shelter □ Street □Transitional
□ Unknown

Gross Household Income:
$ _____ □ **Monthly** □ **Annually**
 # Adults & Children (Under 18) In Household: _____

Military Veteran?
□ Yes
□ No

Migratory or Seasonal Agricultural Worker?
□ Yes
□ No

GUARANTOR (Person to Be Billed, Check here if same as patient □) *

Last Name:	First Name:	MI:	Date of Birth:	Social Security Number:

Street Address:	City:	State:	Zip Code:	County:

MEDICAL INSURANCE

Insurance Company	Policy Holder Name	Relationship to patient	DOB	M/F	Employer	Zip Code

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *

Assignment of Insurance Benefits, Release of Information and Authorization of Treatment.
I the undersigned authorize my insurance benefits to be paid directly to the provider of Bartz-Altadonna Community Health Center for services render. I understand that I am ultimately financially responsible for any balance due for approved and covered charges not paid by insurance. I hereby authorize BACHC to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

Patient/Guardian Signature:_____ **Date:**_____

Relationship to patient_____ **(Write "SELF" if you are the patient)**

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Yearly Consent and Acknowledgment Summary Form

Consents and Acknowledgements

Initial *

By initialing, you confirm that you have received and understood BACHC's "**Consents and Acknowledgements**," "**Telehealth Consent Acknowledgment**," "**Patient Rights and Responsibilities**," "**Minors Rights and Responsibilities**" (if applicable), "**Sterilization Information Acknowledgment**" (if applicable), and the "**Notice of Privacy Practices**." This entails consenting to care, acknowledging patient rights and responsibilities, understanding health information use, and acknowledging financial obligations and the Sliding Fee Scale option.

Patient Acknowledgement of Financial Obligation

Initial *

By initialing, you acknowledge your financial responsibilities at Bartz-Altadonna Community Health Center, including covering care costs, providing reimbursement details, and applying for discounts if eligible. You agree to assist with insurance/benefit applications, pay co-payments and fees at service time, and recognize your self-pay obligations if uninsured.

Advanced Directive Offer Attestation (Only for 18 years or Older)

Initial

By initialing, I acknowledge that I have been informed by Bartz-Altadonna Community Health Center about advance directives, which allow me to state my preferences for end-of-life care. I understand that I have the right to create or update an advance directive at any time.

Staff Use Only – Advance Directive Offer Outcome

□ Accepted: Form given to patient.

□ Declined: Patient chose not to receive the form at this time.

HIPAA Authorization & Pediatric Consent Review (If Applicable)

Initial *

By initialing, you acknowledge that you have reviewed your current HIPAA authorization form and, if applicable, the Consent for Non-Urgent Pediatric Care on file with Bartz-Altadonna Community Health Center (BACHC), and have indicated below whether any updates are needed.

□ Reviewed and no changes needed (HIPAA and pediatric consent if applicable)

□ Reviewed and updated HIPAA and/or pediatric consent (if applicable)

You understand that this authorization allows BACHC to use and disclose protected health information as described in the HIPAA Privacy Policy, the Notice of Privacy Practices, and, if applicable, the Minors Rights and Responsibilities. You may request assistance from clinic staff at any time to update or revoke any of these forms.

By signing below, you confirm your agreement with all documents you have initialed at Bartz-Altadonna CHC, including: "Consents and Acknowledgements," "Telehealth Consent Acknowledgment," "Patient Rights and Responsibilities," "Minors Rights and Responsibilities" (if applicable), "Sterilization Information Acknowledgment" (if applicable), "Notice of Privacy Practices," "Advanced Directive Offer Attestation," "Financial Obligation Acknowledgment," and "HIPAA Authorization." You also authorize BACHC to use and disclose your health information in accordance with federal privacy standards and acknowledge your rights under HIPAA regarding the use of your information for treatment, payment, and healthcare operations.

Patient Signature: *	Patient Printed Name: *	Patient Date of Birth: *	Date: *

If this page is being signed by a personal representative, please fill out the information below:

Signature of Personal Representative or Guardian	Personal Representative or Guardian Name:	Signer Date of Birth:	Date:

Authority of Personal Representative to Sign for Patient (check one): ☐ **Parent** ☐ **Guardian** ☐ **Power of Attorney** ☐ **Other:** _____

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HIPAA Authorization – Release of Health Information

Purpose: This section allows you to authorize Bartz-Altadonna Community Health Center to disclose your health information to individuals you choose.

Patient Information (Required)

Full Name of Patient: _____ Date of Birth: _____

I authorize Bartz-Altadonna Community Health Center to share my personal health information with the following individual(s):

Name:	Relationship:	Phone:	Date of Birth:

Purpose of disclosure (check all that apply): □ Treatment □ Billing □ Other: _____

I understand:

- This authorization is voluntary and may be revoked at any time in writing.
- Revocation will not affect any disclosures already made in reliance on this authorization.
- Information shared may no longer be protected under HIPAA once disclosed.
- This authorization remains valid as long as it is on file, unless a new HIPAA authorization is submitted or this authorization is revoked in writing.

Patient or Legal Representative Signature: _____ Print Name: _____

Relationship to Patient (if not the patient): _____ Date: _____

□ Check here if signer is a parent or legal guardian of the patient.

Type of legal authority (if applicable):
□ Parent □ Legal Guardian □ Healthcare Power of Attorney □ Other:_____

Consent for Non-Urgent Pediatric Care

Purpose: This section allows a parent or legal guardian to authorize another adult to bring their child to Bartz-Altadonna Community Health Center for non-urgent medical care (such as physicals, vaccines, or routine checkups) in their absence.

Child's Information (Required)

Full Name of Child: _____ Date of Birth: _____

I, the undersigned parent/legal guardian, authorize the following individual(s) to bring my child(ren) to Bartz-Altadonna Community Health Center for routine, non-urgent medical care:

Name:	Relationship:	Phone:	Date of Birth:

ONLY FILL FOR MINORS

Legal Authority and Consent
I understand:

- This consent allows the above individual(s) to authorize treatment for my child in my absence.
- This form does not authorize treatment for medical emergencies; in such cases, I will be contacted directly whenever possible.
- I may revoke this consent in writing at any time.
- This consent remains valid as long as it is on file, unless revoked or superseded by a new consent form.

Legal Representative Signature: _____ Print Name: _____

Relationship to Child: _____ Date: _____

Type of legal authority (if applicable):
□ Parent □ Legal Guardian □ Healthcare Power of Attorney □ Other:_____

(Intentionally Left Blank)

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Records should be faxed to BACHC at (866) 572-7851

Authorization to Release or Request Health Information

PATIENT INFORMATION *

Patient Name:	Date of Birth:
Address:	

Phone Number:	Email:	Date of Request:

INFORMATION TO RELEASE/REQUEST FROM

I Authorize BACHC to release/request medical records

□ Release to: _____

□ Request From: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

- **Purpose of this request: □ Transfer of care □ Insurance □ Personal Use □ School □ Legal □ Other:**_____

Request Complete Medical Record or Preventative Care Records: By initialing here, you authorize BACHC to retrieve your complete medical record history or preventive care records. This will assist in understanding and optimizing your care.

_____ * **Initial**

□Preventative Care Records □Complete Medical Record

Specific Information to Release/Request:

□History and Physical Report	□EKG/ECHO	□Pathology Report	□Laboratory Report	□Radiology Report
□Operative Report	□Discharge Summary	□Consultation Report	□Emergency Report	□Billing Record
□Entire Record	□Treatment	□Diagnosis	□Assessment/Evaluation	□Visit Notes

□Other: _____ Treatment Dates: _____to _____

Records may include information related to alcohol or drug use and HIV or AIDS. However, treatment records from drug and alcohol facilities or results of HIV test will not be disclosed unless specifically requested. Mental health and behavioral health information if marked will require a seperate authorization.

□ HIV Information □Drug/Alcohol Treatment Information □Mental/Behavioral Health Information

PREFERRED METHOD OF RECORD DELIVERY

Please select how you would like to receive your medical records. Note that certain options may require identity verification or incur additional charges as allowed by law.

□ Pick-Up in Person : Records will be available at: □ Lancaster Clinic □ Palmdale Clinic (*Valid photo ID required at time of pick-up*)
□ Fax to a Provider or Facility
□ Secure Email (Encrypted): Email Address: _____ (If different then one above)

Authorization to Release or Request Health Information

Records should be faxed to BACHC at (866) 572-7851

YOU ARE REQUIRED TO READ AND SIGN BELOW. I UNDERSTAND THAT:

- **I understand that I am entitled to receive a copy of this signed Authorization upon request.**
- **I have the right to revoke this Authorization at any time by submitting a written request to BACHC.**
- **I understand that signing this Authorization is voluntary and is not a condition for receiving treatment at BACHC.**
- **I understand that revocation will not apply to information already disclosed or to situations where federal law allows an insurer to contest a claim or policy.**
- **This Authorization will remain valid for one (1) year from the date of signature, unless revoked earlier in writing.**
- **I understand that once information is released, it may be subject to re-disclosure by the recipient and may no longer be protected under federal or state privacy laws.**
- **I have the right to inspect or obtain a copy of the health information being used or disclosed pursuant to this Authorization.**
- **I acknowledge that reasonable fees may apply for the reproduction of medical records, as permitted by law.**
- **I understand that specific written authorization is required for the release of sensitive information, including HIV status, substance use disorder treatment, and mental or behavioral health records.**
- **I acknowledge that any release of alcohol or substance use treatment records is protected under federal regulations (42 CFR Part 2), and may not be re-disclosed without my explicit consent.**

Signature: *	**Printed Name:** *(If other than patient, print relationship)* *	**Patient Date of Birth:** *	**Date:** *

BACHC understands the importance of your request and strives to process your request as soon as possible in the order in which your request was received. Please let us know if the requested information is needed by a specific date and every effort will be made to meet your needs. BACHC complies with HIPAA regulations which require processing of requests for medical information within 30 business days of request.

NOTE TO INDIVIDUAL OR ENTITY AUTHORIZED TO RECEIVE ALCOHOL OR SUBSTANCE ABUSE ADDICTION RECORDS Pursuant to This Notice: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2) relating to the confidentiality of alcohol and substance abuse records. Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client of BACHC.

REVOKE THIS AUTHORIZATION FORM

As part of the revocation process, we must inform you about the potential impact on your healthcare if you do not provide authorization to release medical information.

Key Implications:

- **Delays in Treatment: Without access to your comprehensive medical history, there could be significant delays in diagnosis and treatment.**
- **Limited Coordination with Other Providers: Our ability to communicate and collaborate with other healthcare professionals may be hindered, affecting the quality of your care.**

We urge you to consider these implications carefully. If you have any concerns or need further clarification, please contact us immediately.

REVOCATION OF AUTHORIZATION

Name of Patient:	**Signature of Patient/ Legal Representative:**	**Patient Date of Birth:**	**Date:**

Contact person:	**Facility Name:**	**Phone Number:**
Address:		

If signed by someone other than the patient, print name and state relationship and authority

Name of Representative:	**Relationship and Authority:**

Bartz-Altadonna Community Health Center

Grievance Procedure

NON-DISCRIMINATION STATEMENT

Under applicable State and Federal laws and The Bartz- Altadonna Community Health Center (BACHC) policy, we do not unlawfully discriminate in any of its policies, procedures, or practices based on race, religion, color, national origin, sex, marital status, sexual orientation, age, veteran status, medical condition or disability.

Complaints regarding discrimination in the provision of services shall be directed to the address below:

Bartz-Altadonna Community Health Center Clinic Manager, 43322 Gingham Ave, Lancaster, CA 93535

Or

State Department of Health Care Services, 916-445-4171

Further, individuals dissatisfied with the BACHC resolution or decision concerning the complaint of alleged discrimination may appeal the matter to the State Department of Health Services Affirmative Action Division.

L.A Care 1-888-452-2273 / Ombudsman 1-888-452-8609 / DMHC 1-888 -HMO-2219 / DMHC TDD Line 1-877-688-9891

This procedure is in place to effectively manage situations that may present themselves because a client believes they were unfairly mistreated, denied service, discriminated against, harassed, intimidated, or did not receive a proper resolution. However, this process does not guarantee that the outcome will be precisely what the client considers necessary. Each client's case is individual; as such, each case will be managed most appropriately based on its facts and merit.

A step process will be used to manage every case and commence at the agency where the alleged issue occurred. To get the individual Agency Grievance process names and numbers, please refer to the following steps:

1. Contact your case manager or program supervisor for a formal Grievance Procedure and Form.
   a. Then proceed to step 2.
2. Contact the appropriate Program Supervisor at BACHC. Any staff member can provide information and advice on the designees for each department.
   a. If you feel you have not received the proper resolution, go on to the next step.
3. Contact The Bartz-Altadonna Community Health Center Administrative Services Department. Medical Director
   a. If you feel you have not received the proper resolution, go on to the next step.
4. Contact the Bartz-Altadonna Community Health Center Board of Directors in writing. Robert Webb, Bartz Board President
   a. If you feel you have not received the proper resolution, go on to the next step.
5. You may appeal the matter to the State Department of Health Care Services at 916-445-4171. Their decision would be final

Please note that every step follows a specific process. You will not receive assistance if you do not complete the steps in order. For each step, you MUST keep an accurate record of who you spoke to and the time and date. (Use the Grievance Procedure Steps Personal Records Form to maintain accurate records).

I acknowledge receiving, reading, and understanding the above Grievance Procedure.

_____ _____

(Signature of Client) ***(Date)***

_____ _____

(Signature of Bartz-Altadonna Representative) ***(Date)***

43322 Gingham Avenue, Suite 103 Lancaster CA 93535 Bus Phone: 661.874-4050 Fax: 866-572-7851