Health Service Alliance

To help us to give you the best care, we at Health Service Alliance (HSA) need to get to know you and ask that you complete this form to the best of your ability. If you need help filling out this form, please ask our staff for help.

☐ Mr. ☐ Mrs. ☐ Ms _____ _____ _____
Last Name **First Name** **Preferred Name**

_____ _____
Street Address/City/ State/Zip Code **Email**

Date of Birth: _____ **Age**: ____ **Gender**: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Contact Info: Home/Cell Phone: _____ Other Phone: _____
OK to text/voicemail/Email: ☐ Yes ☐ No

Social Security # _____ **Marital**: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced
☐Widowed ☐ Other:_____

Racial/Ethnic Identification: ☐ Hispanic/Latino ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native
☐ Black/African American ☐ White/Caucasian ☐ Other: _____

Preferred Language:☐ English ☐ Spanish ☐ Cantonese ☐ Mandarin ☐ Tagalog ☐ Vietnamese Other:_____

Person to contact in case of an emergency: Name:_____

Relationship: _____ **Phone#**: _____ **Email**: _____

Total Monthly Income: _____ **Total # of persons in your household:** _____

Health insurance: ☐ None; Primary Insurance: _____ Secondary Insurance:_____

Reason for Seeking Care: ☐ Medical ☐ Behavioral Health ☐ Other: _____

Preferred Pharmacy: _____

Preferred Hospital/Date of most recent hospital stay: _____

Social History- Please check all boxes that apply. If you are not comfortable answering, skip to the next section.

Behavioral Health History: ☐ Yes ☐ No; if yes **Have you ever experienced/sought treatment for:** ☐ Depression ☐ Anxiety ☐ Substance Abuse Other:	**Highest level of school you completed:** ☐ Less than Grade 12 ☐ High School diploma/GED ☐ college ☐ Vocational certification ☐ Other: _____
Difficulty addressing basic needs: ☐ Yes ☐ No ☐ food ☐ finances ☐ housing ☐ Transportation ☐ Utilities ☐ Other: _____	**Incarceration History:** ☐ Yes ☐ No ☐ Currently on probation ☐ Currently on Parole ☐ Discharged
Military service: ☐ Yes ☐ No ☐ Active Duty ☐ Discharged	**Employment:** ☐ Employed ☐ Unemployed ☐Retired ☐ Student ☐ Disabled Other: _____

☐ Yes ☐ No- I would like to speak with HSA staff about possible resources for any of the concerns above.

Acknowledgement- Please check appropriate box:

☐ I have filled out this form to the best of my ability and have no questions about this form, or

☐ I have filled out this form to the best of my ability but need help understanding some of the words or questions on this form. I will follow with the HSA staff and/or the treating clinician to get my questions answered.

Patient Name: _____ Signature: _____ Date: _____

For Staff Only:

1. If the patient is unable to provide consent, please ask for a copy of the Health Care Power of Attorney document if completed or a copy of the court order if the patient has a conservator.
2. If the patient is a minor and able to provide consent under the legal requirements for emancipation, please request a copy of the court order or other documentation.
3. If the patient is a minor and able to provide consent under the legal requirements for self-sufficiency, please have the minor complete and sign the form for "Self-Sufficient Minor" (available in HSA forms or in the California Hospital Association Consent Manual).

ACKNOWLEDGEMENT AND CONSENT FOR HSA SERVICES

Patient Name: _____ **Date of Birth:** _____

The Mission of Health Service Alliance (HSA) is to provide you with quality health care, behavioral health and case management services. Our goal is to ensure that all members of our community receive care in a manner that best meets your needs, regardless of religion, ethnicity, race, or gender. To help serve you better, we are required to provide certain information and guidelines to you. Please read the information below and initial each section. If you need help understanding this information, our staff will be glad to assist you.

_____ **Initiation of Services-** I agree to provide requested information to the HSA staff to help them better understand my needs and to cooperate to the best of my ability with care recommendations.

_____ **Hospital Admissions/ER Visits-** I agree to notify HSA every time I seek care at a hospital and will provide my HSA physician with copies of my hospital records.

_____ **Confidentiality-**I understand that all of my information, including my health care information, will be kept private and confidential unless I provide written authorization for it be shared with someone else, except when my information must be released for legal reasons. These reasons include:

- A court order requires HSA to release information;
- I'm in danger of self-harm or of harming others;
- I'm a possible victim of abuse or neglect.

_____ **Confidentiality- Substance Abuse and/or Behavioral Health Records:** I understand that this clinic offers a variety of services and because of this, staff is allowed to view all of my records as a part of providing full scope care. If I have questions/concerns regarding this practice, I will discuss this with my provider.

_____ **Notice of Privacy Practices-**I can request a copy of the Notice of Privacy Practices which explains in greater detail my rights to privacy and how I can access my records. I acknowledge that Privacy Practices are posted.

_____ **E-Mail Disclaimer-** I understand that, if I provide HSA with my e-mail address, I am authorizing this as a form of communicating medical information to me, my representatives and other health care providers involved in my case. If I choose not to allow this type of communication, I will provide a written notification to prohibit this.

_____ **Emergency Access-** HSA has after-hours triage services for emergent/urgent concerns. I understand that for life-threatening emergencies, I will call 9-1-1 or go to the nearest emergency room.

_____ **Financial Terms/Insurance Coverage and Co-pays-** I understand that I may be responsible for obtaining insurance authorization, if needed, for my treatment as well as any co-pays and deductibles. HSA will assist me if I do not understand what steps I need to take and will answer my questions regarding coverage.

ACKNOWLEDGEMENT AND CONSENT FOR HSA SERVICES

_____ **Cancellations and Missed Appointments-** I understand that HSA makes every effort to accommodate my schedule by providing appointment times and reminders. If I repeatedly miss appointments, HSA will discuss with me whether a referral to another provider may be more appropriate for me.

_____ **Fees for Paperwork-** I may have documents that need completion by a health care provider, and I understand that there may be a fee for this request. I recognize that this is a normal part of doing business and agree to pay the fees expected.

_____ **Advance Directive and/or POLST-** I understand that it is important to have my health care wishes in writing should I become too ill to verbally communicate them. I have provided this documentation to the HSA staff for my records. If I do not have an Advance Directive or POLST, and I would like additional education/information, I will request from HSA.

_____ **Medication Management-** I have provided HSA the name of a preferred pharmacy for my prescriptions and agree to only take any medications (prescribed or over the counter) and/or controlled substances as recommended. I understand that, if I am seeking treatment to assist with substance use or medication management, these require regularly scheduled appointments to be successful with my treatment plan and I will keep these appointments to the best of my ability. (For patients seeking treatment for controlled substances, please see "Controlled Substance Agreement" Form).

_____ **Referrals Requiring Authorization:** HSA recognizes how important timely care is, which may include tests and treatment that need approval by my insurance. I understand that this process may take several days in order for my insurance to review my medical needs. I further understand that HSA will keep me updated regarding this process and answer any questions I may have.

_____ **Appeals and Grievances-** I have the right to appeal through my insurance when my care is not certified for coverage, and that there is no penalty to me in exercising this right. I also understand that I may submit a grievance to HSA or my insurance at any time that I want to file a complaint regarding my care. I further understand that I can contact the California Department of Managed Health Care at 800-400-0815 for complaints regarding my managed insurance or grievances regarding an appeal. If I do not have a managed insurance plan, I can also call the local Department of Public Health regarding my complaints or concerns regarding care- 909-383-4777.

_____ **Consent for Coordination with Insurance Company-**I authorize the release of information to my insurance company as necessary for coverage of my health care services at HSA. I further authorize use of my signature to file insurance claims and authorize my insurance to issue payment to HSA and its providers for services rendered.

_____ **Consent for Assessment/Diagnostic Work-up and Treatment-** I authorize and request for my health care or behavioral health care provider to provide all needed diagnostic and treatment services. that best meet my needs. I understand that, through the course of my treatment, my provider will explain all procedures to me and that they are subject to my agreement. I further understand that, while my treatment is intended to be helpful, each patient's response to treatment may be different, and care outcomes may vary.

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_____ **Consent to allow Interns, under the supervision of a licensed clinician, to participate in and provide assessment, care planning and treatment-** I am aware that HSA is a teaching clinic and regularly includes interns as a part of its medical and behavioral health services. I agree to be treated by an intern, if assigned, and recognize that, at any time, I have the right to revoke this consent by verbally notifying the HSA staff.

_____ **Consent for Telehealth Services** – HSA may use telehealth as a type of visit. Telehealth is a remote treatment via the use of technology including phone (audio), texts, emails and audio-visual platforms to provide healthcare services to improve the functioning of the identified patient/client, by a licensed provider. Security and confidentiality of most technology cannot be absolutely guaranteed, but HSA has put safeguards in place including HIPAA compliant wherever possible

- Patients should remember it is important to use a secure internet connection rather than WiFi a public/freeThe use of any form of social media during sessions is prohibited
- HSA will make all reasonable efforts to verify the patient's identity at each session

_____ **Chronic Care Management** - I agree to allow HSA to provide me with Chronic Care Management (CCM) services and to be designated as my CCM Provider if applicable. I understand that only one doctor can provide CCM services for me each month and that I may have to pay a monthly co-payment charge. I also understand that other doctors may from time to time provide CCM services to me under this consent and will receive my medical information electronically form my CCM provider through a computer system or fax (if applicable).

CCM Includes:

- Consultation and guidance in managing my chronic conditions so I can be as healthy as possible
- Reviewing my medications and addressing any questions I may have
- Working closely with home health and/or other healthcare resources in my area
- If I choose to stop CCM services, I understand that I will no longer receive these services from my CCM provider, but this will have no effect on my usual primary care services

ACKNOWLEDGEMENT AND CONSENT FOR HSA SERVICES

***Patient is an adult who:** □ makes own decisions □ is unable to make decisions and the following next of kin makes decisions in his/her behalf: _____ □ Has a medical Power of Attorney/Advance Directive that designates the following agent for decisions and a copy has been provided to HSA: _____ □ Has a court appointed Conservator who makes decisions and a copy of the court order has been provided to HAS.	***Patient is a minor and unable to consent.** Consent will be provided by: □ parent (biological or adopted- excludes step parent) If parents are divorced, parent has provided copy of custody order. □ Foster Parent or County Social Worker; copy of court order provided. □ Court ordered Guardian; copy of court order provided. **Patient is a minor and is able to consent as follows:** □ Pt is 12 or older and is seeking care or prevention of a communicable disease, care for rape/ sexual assault, alcohol/drug abuse treatment, or output mental health treatment. □ Pt is married or previously married. □ Pt is emancipated by court order and has a DMV identification card. □ Pt is 15 or older and is self-sufficient- does not live with family and manages own affairs. □ Pt is seeking to prevent or treat pregnancy (excludes sterilization) or abortion. □ Pt is active duty with the military.

Patient Signature: _____ **Date:** _____

HSA Witness _____ **Date:** _____

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Patient Signature: _____ **Date:** _____

HSA Witness _____ **Date:** _____

Health Service Alliance

Tuberculosis (TB) Evaluation

You and your family may be at increased risk for TB if you answer "yes" to any of the following questions. A person at increased risk for TB should have a yearly TB test. If you have ever had a positive PPD, you should have a chest x-ray every two years.

Patient Name: _____ DOB: _____ Date: _____

1. Where were you born? _____
2. Have you:
   a. Traveled to or have had visitors from any country with high prevalence of TB? (Africa, Asia, Latin America) Yes _____ No _____

   b. Visited or been in a close contact with someone with a history of confirmed or suspected TB? Yes _____ No _____

   c. Lived with anyone who has been incarcerated or lived in an out of home placement facility? Yes _____ No _____

   d. Been exposed to, diagnosed with or in close contact with someone with HIV? Yes _____ No _____

   e. Been exposed to persons who are homeless, migrant workers, or who may use drugs? Yes _____ No _____

3. Have you ever had any of the following for more than 2 weeks?
   a. Persistent Cough Yes _____ No _____
   b. Fever Yes _____ No _____
   c. Night Sweats Yes _____ No _____
   d. Loss of Appetite Yes _____ No _____
   e. Fatigue Yes _____ No _____

4. Have you ever:
   a. Had a positive PPD (TB skin test) Yes _____ No _____
      Date of last check x-ray: _____
   b. Been diagnosed with TB? Yes _____ No _____
   c. Been treated for TB? Yes _____ No _____
   d. Received the BCG (Bacille Calmette-Guerin-Not available in the US) vaccine? Yes _____ No _____

Provider Initials: _____

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