"Healing with Heart"
Elica Health Centers

PATIENT REGISTRATION

Today's Date (month/day/year)	**Preferred Name**	
First Name	**Last Name**	
Social Security Number	**Date of Birth** (month/day/year)	
Home Address		
City	**State**	**Zip Code**
Phone Number	**Alternate Phone Number**	
Email Address		

Legal Sex ☐ Female ☐ Male ☐ Nonbinary ☐ Unknown ☐ X

Gender Identity
☐ Female ☐ Male
☐ Transgender Male/Trans Man/FTM ☐ Transgender Female/Trans Woman/MTF
☐ Non-Binary/Genderqueer ☐ Questioning ☐ Two Spirit
☐ Other ☐ Choose not to disclose

Sexual Orientation
☐ Straight or Heterosexual
☐ Lesbian
☐ Gay
☐ Bisexual
☐ Asexual
☐ Omnisexual
☐ Pansexual
☐ Queer
☐ Something Else
☐ Don't Know
☐ Choose Not to Disclose / Decline

Patient's Sex Assigned at Birth ☐ Female ☐ Male ☐ Intersex ☐ Unknown ☐ Not Recorded on Birth Certificate ☐ Choose Not to Disclose

Marital Status ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

What is your ethnicity?
☐ Not Hispanic, Latino/a or Spanish Origin ☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban
☐ Other Hispanic, Latino/a or Spanish Origin ☐ Unreported / Choose Not to Disclose Ethnicity

What is your race or biological family background? (Check all that apply)
☐ American Indian ☐ Alaska Native ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro
☐ Samoan ☐ White ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Other Race
☐ Unknown ☐ Unreported / Choose Not to Disclose

Emergency Contact

Name	
Phone Number	**Relationship to Patient**

Patient Contacts

Spouse, Mother, Father, Caregiver or Guardian info:

Name_____ **DOB** _____ **Relationship to Patient** _____
Address _____ **City** _____**State** _____ **ZIP Code** _____
Phone Number _____ **Release Medical Information** ☐ Yes ☐ No

Are you experiencing homelessness?
☐ Yes ☐ No (Not Homeless) ☐ Currently Not Homeless (was in the last 12 months)

If Yes, please choose one (1) below
☐ Living in Shelter (Homeless Shelter) ☐ Transitional Housing ☐ Living with Others (Doubling Up) ☐ Street, Camp, Bridge
☐ Homeless Unknown Shelter ☐ Permanent Supportive Housing ☐ Single Occupancy Hotel (Other) ☐ At Risk for Homelessness
☐ At Risk for Homelessness (Child) ☐ At Risk for Homelessness (Veteran)

Are you a migrant / seasonal worker? ☐ Migrant ☐ Seasonal ☐ Neither

Employment

Employment Status ☐ Full time ☐ Part time ☐ Unemployed

Do you need an interpreter? ☐ Yes ☐ No	**Do you speak English?** ☐ Yes ☐ No, My preferred language is _____
English Fluency ☐ Excellent ☐ Very Good ☐ Good ☐ Not Good ☐ Not at All	
Preferred Written Language	**Preferred Language Spoken**

Would you like assistance during your appointment?

☐ Yes, support for Low Vision or Blindness.
☐ Yes, Hard of hearing.
☐ Yes, Mobility Assistance (please describe)_____
☐ Yes, other (please describe) _____

Veteran/Military Status ☐ Yes ☐ No, I am not a veteran (or served in the military)

Additional Demographics

Country of Origin _____
ID/Driver License _____ **State** _____ **Expiration Date** _____

Insurance Guarantor

☐ Self
☐ For children - name of parent or legal guardian _____ Day of Birth (month/day/year) _____
Address *(if different from patient's)* _____ **City** _____ **State** ____ **ZIP Code** _____
Relationship to Patient _____

Total number of people in your household (you and your dependents) _____
What is your household income before taxes $ _____ ☐ Monthly ☐ Yearly ☐ Choose Not to Disclose

What pronouns do you use?

☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Ze/Hir/Hirs ☐ Ey/Em/Eirs ☐ Xe/Xem/Xyrs ☐ Ve/Vir/Virs
☐ Other ☐ Patient's Name ☐ Unknown ☐ Decline to Answer

How do you want us to contact you

Communication Preferences ***(Circle One)***

How would you like to be contacted for Appointments	Phone	Text	Email	Mail
Billing Issues	Phone	Text	Email	Mail
Healthcare Questions / Results	Phone	Text	Email	Mail
Messages from your provider	Phone	Text	Email	Mail

Insurance

Medicare Member ID Number _____ **Effective Date** _____

Medicaid Member ID Number _____ **Effective Date** _____

1. Give receptionist your insurance card and CA ID to copy for your chart
2. Turn in Federal poverty level application and proof of income for sliding scale (if self-pay)
3. Receptionist will scan your documents into your chart

Insurance Name (Anthem, Aetna, HealthNet, etc.) _____

Insurance Member ID _____

Subscriber/Member Name on Card _____

Subscriber DOB _____

Effective Date _____

Insurance Group Info:

☐ Nivano
☐ River City Medical Group
☐ Partnership Health
☐ Hill Physicians
☐ Molina
☐ Other _____
(Name of group i.e; Wellspace, One Community, CHCN, Kaiser, etc.)

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE **DATE**

Consents & Acknowledgements

Treatment: I consent to the treatment that will be provided by Elica Health Centers' (EHC) providers, as well as their assistants and other EHC staff members. I understand that a medical record will be prepared and maintained about me by the clinic, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by the clinic for that purpose. **Initials:** _____

Students/Residents: I understand that EHC participates in the education of students in healthcare. I can decline their participation in my care at any time. **Initials:** _____

Telehealth: I consent to receiving care via telephone, telehealth or patient portal when medically necessary and clinically appropriate to exchange medical information between me and the provider, or between one provider and another provider. **Initials:** _____

Assignment of Benefits: I authorize payment directly to EHC of benefits otherwise payable to me but not to exceed EHC's regular charges for this service. I understand that I am financially responsible to EHC for any charges not covered by my insurance, including the balance of my charges after any discount has been applied. **Initials:** _____

Financial Agreement: I agree to pay all charges that are not payable by insurance or third party. I agree to abide by the terms and conditions of EHC's Collections Policy. Elica Health Centers is not a free clinic and failure to fulfill your financial responsibility to us or agree to a payment schedule may result in your financial discharge from our services. In accordance with EHC's Collection Policy, EHC may choose to terminate its relationship with any patient who does not comply with this financial agreement. **Initials:** _____

Patient Pharmacy Free Choice (As required by U.S. Department of Health and Human Services, Resources and Services Administration (HRSA) and the State of California) I hereby acknowledge that I am free to choose a pharmacy. Any fax or electronic transmission of my prescriptions shall be to the pharmacy or dispensary I select. If I am eligible for medications through a free or discount pharmacy program, I will be directed to a specific dispensary or pharmacy. Elica has free or discounted medications at certain contracted pharmacies. If I chose not to use a contracted pharmacy, I may have that prescription filled at another pharmacy, at a non-discounted price. **Initials:** _____

Notice of Privacy Practices: By signing this form, I acknowledge receipt of the Clinic's Notice of Privacy Practices. **Initials:** _____

Validity of Consent: I understand that this consent will be valid as long as I am a patient or legal guardian of a patient of Elica Health Centers. I have the right to withdraw my consent at any time. If I choose to do so, I must provide that withdrawal in writing to the clinic. The withdrawal of consent will only apply after it is received, and not to any information for which I previously provided consent. **Initials:** _____

Photographs: I consent for photographs to be made of me or my child (or person for whom I am legal guardian). I understand the information will only be used for my health record for identification purposes. **Initials:** _____

Elica Health Centers is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Elica health Centers, OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Elica Health Centers with other OCHIN participants, when necessary for health care operation purposes of the organization is health care arrangement. **Initials:** _____

Open Payments: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. **Initials:** _____

BY SIGNING BELOW, I CONFIRM THAT THE INFORMATION PROVIDED ON THE PATIENT REGISTRATION FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE READ THE CONSENT SECTION, AND UNDERSTAND AND ACCEPT ITS TERMS.

_____ **Print Name of Patient**

_____ **Relationship to patient of Individual Signing Form** (for example, patient, parent, guardian)

_____ **Patient/Guardian Signature**

_____ **Date**

_____ **Witness (Clinic Staff Member)**

_____ **Date**

"Healing with Heart"
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ADULT & PEDIATRIC AGE 12+ HEALTH HISTORY

Patient Name:	**Date of Birth:**

We ask everyone about their reproductive health needs.
Pregnancy Intention Screening Questions

Are you currently pregnant? ☐ Yes ☐ No

What was the first day of your Last Menstrual Period, if menstruating? Date:_____ ☐ N/A

Are you currently breastfeeding? ☐ Yes ☐ No

Do you want to become Pregnant? ☐ Yes ☐ No ☐ Unsure ☐ Ok either way ☐ N/A

Do you want to talk about contraception or pregnancy prevention today? ☐ Yes ☐ No

ALLERGIES TO ANY MEDICATIONS, FOOD OR OTHER SUBSTANCES?

Allergic to:	**Reaction:**	**Severity of Reaction:**
	☐Anaphylaxis ☐ Hives ☐Rash ☐ Swelling ☐Nausea/vomiting ☐Other:_____	☐Low ☐Medium ☐High
	☐Anaphylaxis ☐ Hives ☐Rash ☐ Swelling ☐Nausea/vomiting ☐Other:_____	☐Low ☐Medium ☐High
	☐Anaphylaxis ☐ Hives ☐Rash ☐ Swelling ☐Nausea/vomiting ☐Other:_____	☐Low ☐Medium ☐High

MEDICAL HISTORY (Check all diseases and medical conditions that apply)

☐No Past Medical History

☐Abuse as Adult (victim)	☐Depression	☐Liver disease
☐Abuse as a child (victim)	☐Diabetes mellitus	☐Meningitis
☐Allergies	☐Emphysema/COPD	☐Myocardial infarction
☐Anemia	☐GERD	☐Nerve/Muscle disease

☐Anxiety	☐Glaucoma	☐Osteoporosis
☐Arthritis / Joint disorder	☐Heart disease	☐Seizures
☐Asthma	☐Heart Failure	☐Sickle cell anemia
☐Blood Transfusion	☐Heart murmur	☐Stomach ulcers
☐Cancer	☐HIV/AIDS	☐Stroke
☐Cataracts	☐Hyperlipidemia	☐Substance abuse
☐Clotting disorder	☐Hypertension	☐TB disease
☐COPD	☐Kidney disease	☐Thyroid disease
☐Other, please explain:		

SURGICAL HISTORY		
☐No Past Surgical History		
☐Appendectomy	☐Cosmetic surgery	☐Small intestine surgery
☐Brain surgery	☐Eye surgery	☐Spine surgery
☐Breast surgery	☐Fracture surgery	☐Third Molar Extraction
☐CABG	☐Hernia repair	☐Tonsillectomy
☐Cholecystectomy	☐Joint replacement	☐Valve replacement
☐Colon surgery	☐Prostate surgery	☐Vasectomy
☐Other, please explain:		

FAMILY HISTORY (Check all diseases and conditions that apply):

Relationship	Name	No Known Problems	Alcohol/Drug Use	Allergies	Alzheimer's Disease	Anemia	Autoimmune Disease	Breast Cancer	Colon Cancer	Caner	Depression	Diabetes	Heart Attack	High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Lung Disease	Stroke	Sudden Death	Suicide	Thyroid Disease	Vision Problems	Other
Mother																								
Father																								
Sister																								
Brother																								
Daughter																								
Son																								
Maternal Aunt																								
Maternal Uncle																								
Paternal Aunt																								
Paternal Uncle																								
Maternal Grandmother																								
Maternal Grandfather																								
Paternal Grandmother																								
Paternal Grandfather																								
Other																								

LIST ANY OTHER FAMILY MEDICAL HISTORY BELOW:

Disease or medical problem:	Family member:

TOBACCO USE

Do you use E-Cigarettes or Vape any substances?
☐Never used ☐ Former user, quit date: _____ ☐Yes, every day ☐ Yes, some days

If yes, what substance? ☐Nicotine ☐ THC ☐ CBD ☐ Flavoring ☐ Other: _____

Do you smoke any tobacco products? (cigarettes, cigars, etc)
☐Never used ☐ Former user, quit date: _____ ☐Yes, every day ☐ Yes, some days

Do you use any smokeless tobacco? (chew, snuff, dissolvables, etc)
☐Never used ☐ Former user, quit date: _____ ☐Yes

Are you, or have you been in the past, regularly exposed to smoke? (Passive exposure)
☐Never ☐ Past ☐ Current

ALCOHOL INTAKE

Do you ever drink alcohol? ☐ Yes ☐ Not currently ☐ No

How many drinks per week, and of what? _____ drinks of _____ per week

DRUG USE

Do you currently (in the last 6 months) any recreational drugs? ☐ Yes ☐ Not currently ☐No

Which drugs do you use? ☐ Vaping ☐Marijuana ☐Opioids (Fentanyl, Codeine, Oxy, Norco, etc) ☐ Heroin ☐Methamphetamine ☐ Amphetamines (Adderall) ☐ PCP ☐ Ecstasy (MDMA, Molly) ☐ LSD (Acid) ☐Ketamine ☐Mescaline (Peyote) ☐ Psilocybin (Magic Mushrooms, 'Shrooms) ☐ Cocaine ☐Crack ☐Nitrous Oxide ☐ Solvent Inhalants (Poppers, etc) ☐ Barbiturates ☐ Benzodiazepines (Xanax, Ativan, Klonopin) ☐IV use(Needle to inject drugs)
☐Other: _____

SEXUAL ACTIVITY

Sexually active: ☐ Yes ☐ Not Currently ☐ Never

Birth Control / Protection: ☐ Abstinence ☐ Cervical Cap ☐ Condom ☐ Diaphragm ☐ Fertility Awareness Method ☐ Hormonal Patch ☐ Implant ☐ Injection ☐ Inserts ☐ I.U.D ☐ IUS ☐ Menopause ☐ Pill ☐ Rhythm ☐ Spermicide ☐ Sponge ☐ Surgical ☐Vaginal Ring ☐ Vasectomy ☐Withdrawal ☐ None

Partners: ☐ Male ☐ Female ☐ Transgender Female / Male-to-Female ☐ Transgender Male / Female-to-Male ☐Non-binary / genderqueer ☐ Questioning ☐ Other ☐ Choose not to disclose

Comments: _____

PREGNANCY (OBSTETRIC) HISTORY

Have you ever been pregnant? ☐ Yes ☐ No ☐ N/A

If yes, how many times TOTAL have you been pregnant? _____ (Gravida)

- How many babies have you delivered? _____ (Para)
- How many babies were full term? (37 weeks or more) _____ (Term)
- How many babies were premature (less than 37 weeks)_____ (Preterm)
- How many living children do you have? _____ (Living)
- How many miscarriages have you had? _____ (SAB)
- How many abortions have you had? _____ (IAB)

Have you ever had any pregnancy or birth complications? _____

_____

_____

_____

AUDIT

1. How often do you have a drink containing alcohol? (0) Never *[Skip to Qs 9-10]* (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	7. How often during the last year, have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0	8. How often during the last year, have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year, have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (1) Yes, but not in the last year (2) Yes, but during the last year
5. How often during the last year, have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (1) Yes, but not in the last year (2) Yes, but during the last year

DAST

These questions refer to the past 12 months.

1. Have you used drugs other than those required for medical reasons?	☐Yes	☐No
2. Do you abuse more than one drug at the time?	☐Yes	☐No
3. Are you always able to stop using drugs when you want to? (If never used drugs, answer “Yes.”	☐Yes	☐No
4. Have you had “blackouts” or “flashbacks” as a result of drugs?	☐Yes	☐No
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose “No.”	☐Yes	☐No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	☐Yes	☐No
7. Have you neglected your family because of your use of drugs?	☐Yes	☐No
8. Have you engaged in illegal activities in order to obtain drugs?	☐Yes	☐No
9. Have you ever experienced withdrawal symptoms (feel sick) when you stopped using drugs?	☐Yes	☐No

10. Have you had medical problems as a result of your drug use (e.g.,memory loss, hepatitis, convulsions, bleeding, etc.)?	☐Yes	☐No

PHQ-9

Over the last two weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

GAD-7

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

TB RISK ASSESSMENT		
Recent close or prolonged contact with someone with infectious TB disease	☐Yes	☐No
Born in or recent traveler to high prevalence area (see flowsheet sidebar for country list)	☐Yes	☐No
Chest radiographs with fibrotic changes suggesting inactive or past TB	☐Yes	☐No
HIV infection	☐Yes	☐No
Organ transplant recipient	☐Yes	☐No
Immunosuppression secondary to use of prednisone (equivalent of > or = to 15mg/day for >or = 1 month) or other immunosuppressive medication such as TNF -o antagonist	☐Yes	☐No
Injection drug user	☐Yes	☐No
Resident or employee of high-risk congregate setting (e.g., prison, long-term care facility, hospital, homeless shelter)	☐Yes	☐No
Medical condition associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer if head or neck, Hodgkin's Disease, leukemia, and end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal for given population)	☐Yes	☐No

Signs/Symptoms of TB ☐ Cough lasting ☐ Persistent fever ☐Unexplained weight loss ☐ Loss of appetite ☐Persistent sweats
☐ Chronic fatigue ☐ Chills ☐Coughing up blood ☐Shortness of breath ☐ Chest pain ☐None

SOCIAL HISTORY (PRAPARE)

What is the highest grade or year of school you completed?
☐Never attended school or only attended kindergarten ☐ Grades 1 through 8 (Elementary) ☐Grades 9 through 11 (Some high school)
☐Grade 12 or GED (High school graduate, diploma, or alternative credential)
☐College 1 year to 3 years (Some college, Associate's degree, trade, vocational school)
☐College 4 years or more (College Graduate) ☐ Declined

How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?
☐Not hard at all ☐Somewhat hard ☐ Very hard ☐Decline

What is your living situation today?
☐I have a steady place to live
☐I have a place to live today, but I am worried about losing it in the future
☐I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the streets, on the beach, in the car..)
☐Decline

In the past 12 months, has lack of transportation kept you from medical appointments, meeting, work or from getting things needed for daily living?
☐Yes, it has kept me from medical appointments or getting medications
☐Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
☐No
☐Declined

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends in the phone, visiting friends or family, going to church or club meetings)
☐Less than once a week ☐ 1-2 times a week ☐ 3-5 times a week ☐ 5 or more times a week ☐Decline

Do you feel these kinds of stress these days? ☐Not at all ☐ A little bit ☐Somewhat ☐ Quite a bit ☐Very much ☐ Decline

Are you currently employed? ☐Yes ☐ No ☐Decline

Would you like assistance with any of the above items? ☐Yes ☐ No

Type of assistance: ☐Written information ☐ Contact me

What do you want help with?
☐Health Literacy ☐ Education ☐ Financial Strain ☐Housing ☐ Food ☐Transportation ☐Utilities
☐Physical Activities ☐ Stress ☐ Isolation ☐ Relationship ☐ Employment

MEDICATION
(List all current medications: prescribed, over-the-counter drugs, vitamins & inhalers and the dosage)

Medication	Dosage	Frequency

ARE YOU CURRENTLY UNDER THE CARE OF ANY OTHER PHYSICIANS OR SPECIALISTS?
(LIST ALL BELOW)
Medical Assistant: Complete a medical record release form for all medical providers listed below and add to Care Team in Epic

Physician/Practice Name	Specialty	Address	Phone

DENTAL HISTORY

1. Have you had problems with prior dental treatment?	☐Yes	☐No
2. Date of last dental exam:		
3. Have you ever been pre-medicated for dental treatment? If yes, why?	☐Yes	☐No
4. Have you taken bisphosphonates?	☐Yes	☐No

ALLERGIES AND REACTIONS

Are you allergic to Latex? If yes, please explain the reaction.	☐Yes	☐No
Are you allergic to local anesthetic? If yes, please explain the reaction.	☐Yes	☐No
Are you allergic to Nitrous oxide? If yes, please explain the reaction.	☐Yes	☐No

"Healing with Heart" Elica Health Centers

PATIENT PRIVACY

Elica Health Centers (EHC) wants to do all we can to protect your private health information. Telling EHC how you want to share information is called HIPAA Authorization. This form is to help us know what details, if any, you would like us to share with the people in your life. Behavioral Health providers do not/will not communicate with any patients regarding their treatment or care via email and/or text.

Patient Information			
Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**
Legal Parent/Guardian/ Conservator #1 (if applicable):		**Legal Parent/Guardian/ Conservator #2 (if applicable):**	

Message Preferences: Tell us the type of messages you prefer and what we can share. (Messaging and data rates may apply.)	Phone	Text	Email/Portal
All of the below	☐	☐	☐
Health Notifications (such as lab or test results)	☐	☐	☐
Appointment Reminders	☐	☐	☐
Announcements (such as new programs or community information)	☐	☐	☐
Billing Notifications	☐	☐	☐

Who: Tell us who you would like us to share, or release, information with. Each box is for a different person.

Person #1		**Person #2**	
Name:		**Name:**	
Relationship:		**Relationship:**	
☐ We can tell this person any and all of your medical information.		☐ We can tell this person any and all of your medical information.	
OR		**OR**	
☐ We can give this person today's chart notes at the time of the visit.		☐ We can give this person today's chart notes at the time of the visit.	
☐ We can give this person all of your test results.		☐ We can give this person all of your test results.	
Office Use Only		**Office Use Only**	
Effective Date:	Updated by:	Effective Date:	Updated by:
Revoke Date:	Updated by:	Revoke Date:	Updated by:

Person #3		**Person #4**	
Name:		**Name:**	
Relationship:		**Relationship:**	
☐ We can tell this person any and all of your medical information.		☐ We can tell this person any and all of your medical information.	
OR		**OR**	
☐ We can give this person today's chart notes at the time of the visit.		☐ We can give this person today's chart notes at the time of the visit.	
☐ We can give this person all of your test results.		☐ We can give this person all of your test results.	
Office Use Only		**Office Use Only**	
Effective Date:	Updated by:	Effective Date:	Updated by:
Revoke Date:	Updated by:	Revoke Date:	Updated by:

☐ **I do not want ANYTHING told or shared with ANYONE.**

By signing this form, I acknowledge receipt of the Clinic's **Notice of Privacy Practices** and authorize Elica Health Centers to share my health information to the listed individuals as indicated above.

_____ _____

Print Name of Patient | Relationship to Patient of Individual Signing Form (for example, patient, parent, guardian, caregiver)

_____ _____

Patient/Guardian Signature | Date

_____ _____

Witness (Clinic Staff Member) | Date

"Healing with Heart"
Elica Health Centers

SLIDING FEE DISCOUNT PROGRAM APPLICATION

At Elica Health Centers, we offer a Sliding Fee Discount to make our services more affordable to all patients.

- If you already receive Social Security Disability income (SSDI), Temporary Assistance for Needy Families (TANF), or any other public assistance programs, you may be eligible for the Sliding Fee Discount Program.

The following criteria apply to the sliding fee scale, which is based on the current Federal Poverty Guidelines (FPG):

- You must complete the application on the reverse and re-apply in six months, or when your household or income changes, whichever comes first.
- You are required to provide proof of income as instructed on the application. Self-declaration of income will qualify the patient for one visit only, but can be changed within ten days of visit.
    - If you have no income or are unable to provide proof of income, please fill out the self-declaration form. You may still be eligible for the Sliding Fee Discount Program.
- Approval is based on household size and gross income.
- Participants are expected to pay their share of the discounted fee at the time of service.
    - Patients can also arrange to make regular payments until the balance is paid.
    - A charge for today's services will reflect the sliding fee scale below. If you qualify on the sliding fee scale, this will be your nominal fee and no other charges will be billed.
    - Sources of acceptable payments are:
        1. Cash
        2. Credit Cards (VISA, MasterCard). Checks are not acceptable.

If eligible to enroll in Medi-Cal, please ask us for more information. We would be happy to provide resources such as:

- Evaluation if you are eligible for full scope Medi-Cal
- Assistance with filing the MC-13 PRUCOL form
  (if you only have Emergency Medi-Cal and want to request full coverage)
- Provide Department of Human Assistance location contact information or help schedule a visit with Sacramento Covered
- Provide information and estimate income limits for Medi-Cal or other programs.
- Provide information and help find information about programs (e.g., for oncology, diabetes) if the patient is not eligible for any insurance.

If you have questions, please contact a staff member from one of EHC locations, or call at (916) 454-2345.

SLIDING FEE DISCOUNT SCHEDULE

Elica Health Centers: Sliding Fee Schedule			Sliding Fee Scale: (Based on Federal Register Poverty Income Guidelines)			
Discount Categories	**Category A**	**Category B**	**Category C**	**Category D**	**Category E**	**Full Pricing**
% of Federal Poverty Income Levels	**At or below 100% (FPG)**	**>100 - 125%**	**>125 - 150%**	**>150 - 175%**	**>175 - 200%**	**> 200 %**
Medical / Behavioral Health	**Nominal Fee**	**Discounted Fees**				**Full Pricing**
All Inclusive Visit (1)	**$25**	**$35**	**$45**	**$55**	**$65**	
Internal Diagnostic labs (2)	**$5**	**$6**	**$7**	**$8**	**$9**	
Lab referral (3)	**$30**	**$31**	**$32**	**$33**	**$34**	
Electives & Other Special Items (see schedule below) (4)	**see #4 below**					
Dental Program	**Nominal Fee**	**Discounted Fees**				**Full Pricing**
All Inclusive Visit: diagnostic, preventive, periodontal, & emergencies (1)	**$25**	**$35**	**$45**	**$55**	**$65**	
Major / Bundled Professional fees: bridges, crowns, dentures, & root canals (5)	**$25**	**$35**	**$45**	**$55**	**$65**	
Major / Bundled: lab/equipment (5)	**see schedule below**					

1. All-inclusive visits include professional services and all routine supplies, injectables, and vaccines.
2. Internal labs are medical diagnostic labs performed on site.
3. Lab referrals are medical diagnostic labs performed off site by Quest Diagnostics or other reference labs.
4. Electives and other special items with special pricing (based on actual cost):

   Depo Provera $45 — Other IUDs $600

   Liletta IUD $105 — Night guards $95
5. Major/Bundled Dental includes services such as treatment planning, special labs and/or equipment. These services may be bundled into two or more appointments. An Elica Treatment Coordinator will explain the process and provide financial counseling services. The patient is expected to pay 50% before services can begin and the remaining balance will be set up on a payment plan. See schedule below.

Patient pays discounted professional fee for each visit plus a one-time fee according to this schedule:

Major Service	**Category A**	**Category B**	**Category C**	**Category D**	**Category E**	**Full Pricing**
Root Canal (per canal)	**$175**	**$200**	**$225**	**$250**	**$275**	
Crown/Bridge (per unit)	**$150**	**$170**	**$190**	**$210**	**$230**	
Full Denture (per arch)	**$400**	**$450**	**$500**	**$550**	**$600**	
Partial Denture (per arch)	**$450**	**$500**	**$550**	**$600**	**$650**	

APPLICATION FOR SLIDING FEE PROGRAM ELIGIBILITY

1. Have you applied for Medi-Cal, and been DENIED benefits within the last 60 days? ❒ Yes ❒No
2. Total Number of dependents living in your household (include yourself/spouse, children, and any taxable dependent relatives living with you: _____

You must provide proof of income for every adult household member. Examples are: a copy of the most recent tax return, your two most current pay stubs or W2's, child support check stubs, social security statements, disability / workers' compensation check stubs, letter of support, etc. Please ask for help in determining acceptable proof of income. You must submit documentation within 10 days of your application. Failure to do so will result in the return of your application and delay in approval.

Patient Name: _____ Birth Date: _____

					For Internal Use Only	
Name	Relationship	Date of Birth	Income Amount	Income Type	Date Received	Type of Documentation
	self			❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		

I hereby request Elica Health Centers to determine my eligibility for the sliding fee program, based on the information I have submitted. I understand that the information, which I submit concerning my family income and size, is subject to verification. I also understand that if the information, which I submit, is determined to be false, I will be liable for all services at full charge. In signing this application, I affirm that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Elica Health Centers of all changes to my insurance information and should I fail to do so, payment in full of all services rendered will be my responsibility.

Signature: _____ Date:_____

VERIFICATION AND DETERMINATION (Office Use Only)

1. Monthly income verification attached: ❒ Yes ❒ No (Initial Self-Declaration)
2. Slide Effective Date: _____
3. Qualified fee reduction: ❒ ≤100% ❒ 101-125% ❒ 126-150% ❒ 151-175% ❒ 176-200% ❒ ≥200%
4. Length of reduction: ❒ 1st Visit ❒ 6 months

Verification and determination by: _____ Date: _____

"Healing with Heart"
Elica Health Centers

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name	**MRN:**	**Today's Date** (month/day/year)
Date of Birth (month/day/year)		

SELF-DECLARATION FORM

I, _____, do hereby attest that:

❒ **Option 1: Cash Income**

I am unable to provide proof of income due to the nature of my work. I attest that

I receive _____ per (hour / month / annual / other: _____).
(dollars) (please choose one of the above options)

❒ **Option 2: Letter of Support**

I receive _____ per month from _____ (_____)
(dollars) (supporter's name) (relationship)

❒ **Option 3: No Income**

Neither I nor any other member of my household has any source of income.

❒ **Option 4: Not Applicable**

I am able to provide proof of income, therefore the above options do not apply to me.

By signing below, I agree that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Elica Health Centers of all changes to my income and support.

_____ _____
Patient / Representative Signature Date

_____ _____
Print Name Relationship to Patient