OLE HEALTH

Place Patient Label Here

PATIENT REGISTRATION AND CONSENT

Please help us serve you and our community by providing answers to the questions below. Some information provided is used to acquire grant funds that help uninsured and underinsured people in our community.
Your responses will remain confidential.

First Name	Last Name	SSN
Preferred Name (if different)	DOB	**Are you ok with receiving text messages?** ☐ Yes ☐ No

Legal Sex
☐ Female
☐ Male
☐ Unknown
☐ Intersex (X)
☐ Non-Binary

Gender Identity
☐ Female
☐ Male
☐ Non-Binary
☐ Genderqueer
☐ Other
☐ Transgender Male
☐ Transgender Female
☐ Questioning
☐ Two Spirit
☐ Choose Not To Disclose

Sex Assigned at Birth
☐ Male ☐ Female

Pronouns
☐ He/Him/His ☐ She/Her/Hers
☐ They/Them/Theirs ☐ Other: _____

Sexual Orientation
☐ Straight ☐ Lesbian ☐ Omnisexual ☐ Something Else: _____
☐ Gay ☐ Pansexual ☐ Asexual ☐ Don't Know
☐ Bisexual ☐ Queer ☐ Choose Not to Disclose

Address	**City, State**	**Zip Code**	**County**
Home Phone	**Work Phone**	**Mobile Phone**	**Email**

Emergency Contact (Please print "none" below if you do not have an emergency contact)

Name (First and Last)	Relation to Patient	Telephone Number

For patients under 18, provide guarantor/legal guardian information (This person will be listed as the decision-maker and responsible financial party):

Name (First and Last)	DOB	Relation to Patient	Guarantor Telephone

Marital Status
☐ Married ☐ Widowed ☐ Domestic Partner
☐ Single ☐ Legally Separated
☐ Divorced ☐ Unknown
☐ Other ☐ Significant Other

Ethnicity/Ethnic Group
☐ Mexican, Mexican American, or Chicano/a ☐ Cuban
☐ Multiple Hispanic, Latino/a, or Spanish Origins ☐ Puerto Rican
☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Don't Know
☐ Choose Not To Disclose ☐ Non-Hispanic or Latino/a

Race (please select up to five):
☐ Alaskan Native
☐ American Indian
☐ Asian Indian
☐ Black/African American
☐ Chinese
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ White
☐ Filipino
☐ Samoan
☐ Other Asian
☐ Native Hawaiian
☐ Don't Know
☐ Choose Not To Disclose

Preferred Language Spoken:

Do you need interpreter services?
☐ Yes ☐ No

Are you Disabled?
☐ Yes ☐ No

Veteran/Military Status:
☐ Active Duty ☐ Inactive Duty ☐ Reservist ☐ Veteran ☐ No Previous Experience

Where are you currently living?
☐ Home/Apartment ☐ Outside (Street/Car)
☐ Transitional House ☐ With Friends/Family
☐ Shelter ☐ Other

Are you a seasonal/migrant agricultural worker? (check all that apply):
☐ Migrant Agricultural worker: my main job is agriculture, and I move to find my jobs
☐ Seasonal agricultural worker: My main job is agriculture, and I don't work year-round

This information is important to our funding as a federally qualified health center and helps us better serve our patients:

How many people are in your household?

How much income did everyone in your house get last month before taxes?

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CONSENTS

To provide treatment, bill your insurance, or release information required by your insurance carrier, etc., OLE Health (OLE) must receive your consent and acknowledgement by initialing the areas indicated and providing your signature below.

_____ Initial **Assignment of Benefits:** I understand that OLE will bill my insurance, and I agree to assign to all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by OLE.

_____ Initial **Consent to Bill:** I understand that I am financially responsible for all remaining balances associated with services rendered, including but not limited to deductibles, co-pays, any out-of-network costs, and/or charges not covered by my insurance plan.

_____ Initial **Consent of Treatment:** I authorize OLE and its medical, nursing, and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of OLE's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by OLE personnel.

_____ Initial **Consent to Telehealth:** Beneficiaries have the right to access covered services via telehealth, which involves the use of audio, video, or other electronic communications to interact with patients, consult with healthcare providers and/or review medical information for the purpose of diagnosis, therapy, follow-up and/or education. During a telehealth visit, details of my medical history and personal health information may be discussed with other health professionals using interactive video, audio, and telecommunications technology. Additionally, a physical examination may take place and video, audio, and/or photo recordings may be taken. The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. I understand that telehealth visits are voluntary, and my consent can be withdrawn at any time. I acknowledge there may be limitations or risks related to receiving services through telehealth as compared to an in-person visit including, but not limited to, potential connectivity issues, a restricted ability to perform a comprehensive physical examination or deliver immediate intervention, etc. I authorize OLE and its medical, nursing, and other professional staff members, to provide telehealth care services if it is advisable in my care.

_____ Initial **Patient Consent for E-prescribing and Web Portal Invite:** I agree that OLE may e-prescribe my prescriptions and may request and use my prescription medication history from their healthcare providers or third-party pharmacy benefit payers for treatment purposes. Additionally, if I provided an email address, I understand OLE will send me an invitation to join the web portal, and I have received a copy of the Patient Portal User Agreement.

_____ Initial **Taking of pictures and/or recording of video/audio:** I consent to clinic photo, audio, or video recording by OLE and its medical, nursing, and other professional staff members. I understand that the purposes of these photos are for identification, documentation processes of diagnosis and/or treatment. I acknowledge that these photo/audio/video recordings are used for the provision of care, quality improvement, education, and/or reimbursement purposes.

ACKNOWLEDGEMENTS

Notice of Privacy Practices: I acknowledge that I have been offered a copy of OLE's Notice of Privacy Practices that describes my rights and how my information may be used for treatment, billing, and operations. By signing below, I indicate that I am aware this notice is available online at www.olehealth.org, and that I may receive a copy by requesting one from any OLE registration staff member."

FTCA Acknowledgement: I acknowledge receiving notice that under federal law relating to the operation of health centers, the Federal Tort Claims Act (FTCA) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions within the scope of any clinic volunteer or employee health practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. (See Public Health Service Act subsection 224(q), codified at 42 U.S.C. § 233(q) This acknowledgment of notification of the limitation on liability is being provided before health care services have been provided to me by this individual.

Open Payments Database: 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. I acknowledge that OLE has notified me about the Open Payments Database.

No Show Policy: A "no-show" refers to a patient who misses an appointment without cancelling/re-scheduling with at least 24-hour notice by phone, portal, text, or in-person. To accommodate the significant number of individuals waiting for appointments, I acknowledge that if I "no show" to three (3) appointments in a 6-month period, I may not be allowed to make scheduled appointments and may have to come in on a walk-in only basis for a six-month period.

Late Policy: I acknowledge that if I am more than 5 minutes late for my appointment, I may need to wait to be seen at the next available opening. Please note: While every effort will be made to see you, we cannot guarantee an appointment will be available. You are more than welcome to reschedule your appointment if you are unable to wait.

Transportation Assistance: I understand that transportation for Medi-Cal beneficiaries is available for in-person visits if I am having trouble traveling to and from my appointments.

SIGNATURES

Patient Name (please print):_____ Date:_____

Patient Signature: _____ Date:_____

Legal Guardian Name (if applicable):_____ Relationship to Patient: _____

Legal Guardian Signature: _____ Telephone Number:_____