ASIAN PACIFIC HEALTH CARE VENTURE, INC.
"working together for community health"

Patient Registration

Date: _____

Patient Last Name	**Patient First Name**	**Patient Middle Name**

Social Security #	**Date of Birth** (mm/dd/yyyy)	**Gender at birth:** □ Male □ Female

Current Gender: □ Male □ Female	**Gender Identity** □ Male □ Female □ Transgender Male □ Transgender Female □ Other □ Choose Not to Disclose

Street Address			**Cell Phone**
City	**State**	**Zip**	**Home Phone**

What is your marital status? (check one) □ Divorced □ Married □ Single □ Domestic partner □ Separated □ Widowed	**Day Phone**
Student Status: (check one) □ Full time □ Part-time □ Not a student	**Preferred Phone Number:** □ Home □ Cell □ Day
Patient Email Address:	**Contact Preference:** □ No Preference □ Phone: When is the best time? □AM □ PM □ Eve □Anytime □ Email/ Patient Portal □ Mail

Race: Please select **all apply** from the following race listing:

□ Asian Indian
□ Bangladeshi
□ Cambodian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Thai
□ Vietnamese
□ Other Asian:_____
□ American Indian/Alaska Native
□ Black/African American
□ Native Hawaiian
□ Guamanian or Chamorro
□ Samoan
□ Other Pacific Islander: _____
□ White

Preferred language?	**Birthplace:** □ United States □ Other:_____

Year Arrived in US: Please put N/A if you're born in U.S.	**What is your highest Level of education completed?** (Check one) □ Elementary □ Junior High School □ High School □ College □ Graduate Degree or Higher □ N/A

Do you have a physical or mental disability that has prevented or will prevent you from working for more than a year? □ Yes □ No	**Is it okay to send mail to your address** □ Yes □ No
Emergency Contact Information **Last Name:** **First Name**	**Relationship to patient:** □ Spouse □ Friend □ Parent/Legal Guardian □Other
Emergency Contact Phone number: □ Home □ Work □ Cell	

Patient's Parent/Guarantor Information (Parent or Legal Guardian for Children Under 18 years)

Parent 1 Information **Last Name:** **First Name:**	**Relationship to patient:** □ Parent □ Foster Parent □ Step parent □ Legal Guardian □ Other	
Parent Address **City** **State** **Zip**		**Parent Email address:**
Parent Phone Number	**Parent Date of Birth** (mm/dd/yyyy)	**Parent/Guarantor Gender** □ Male □ Female
If NO second Parent/Guarantor information: Please check the box □ (and skip to Patient Information)		
Parent 2 Information **Last Name:** **First Name:**	**Parent/Relationship to patient:** □ Parent □ Foster Parent □ Step parent □ Legal Guardian □Other	
Parent Address **City** **State** **Zip**		**Parent Email address:**
Parent Phone Number	**Parent Date of Birth** (mm/dd/yyyy)	**Parent Gender** □ Male □ Female

Patient Information

Birth Mother's Full Name (before marriage)
Last (Maiden Name) First Name Middle Name

Are you Homeless? □Yes □ No	**Are you a LAUSD student?** □Yes □ No
Are you or your family members <u>Migratory or Seasonal</u> Agricultural Workers? □ Yes □ No	**Are you a veteran of US Armed Forces?** □ Yes □ No
Do you need an Interpreter? □ Yes □ No	**Ethnicity: Are you Hispanic, Latino/a or Spanish Origin?** □Yes □ No If Yes, select all apply: □ Mexican, Mexican American, Chicano/a □ Puerto Rican □ Cuban □ Central American □ South American □ Hispanic or Latino, Unknown Origin □ Another Hispanic, Latino/a, or Spanish Origin: _____
How many people in your family? only include yourself, spouse and minor children under 18 years	**What is your household annual income?** Combined income of the persons listed in your family, if they are working

How did you hear about our clinic? (Please circle all that apply)

APHCV Employee	Brochure/Flyer	Building Signage	Family/Friend/Patient
Health Fair/Festival/Events/Outreach		HMO/Insurance List	Hospital/Doctor/Business/Agency
Internet-Facebook/Instagram		Internet-APHCV Website/Google/Yelp/Etc.	
Newspaper/Magazine/Yellow Pages		School/Outreach	Other: _____

Name of the person who completed the form if it's different from patient: _____

Please turn in the completed forms to Front Office staff.
Thank you.

(SBHC use only)
Parent verification by:
_____
Date: _____

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
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General Medical and Behavioral Health Consent for Care

Patient Identifying Label

A. CONSENT TO TREATMENT:

I hereby request and consent to diagnostic procedures, tests, and medical/mental health treatment, family planning and immunizations as deemed advisable by the professional staff of Asian Pacific Health Care Venture, Inc. (APHCV). I am aware that a Physician, a Nurse Practitioner, a Physician Assistant, or Behavioral Health Provider may provide the medical/mental health care. In addition, the care may be provided by Nurses, Registered Dietitian, support staff, and specialists if such a referral is made. I also give consent to share diagnoses and treatment needed information to specialists in my care when referred by my Provider.

I consent to the taking of photographs, videotapes, digital or other images of my medical condition by clinical staff especially when needed to help specialists provide care for me. I also consent to use of such images for enhancing clinical operations including peer review and education of staff. A separate consent is required by me for use of any image for non-clinical purposes.

Clinical tests at APHCV may include HIV testing. Such testing is highly recommended to be done at least by US best practice guidelines unless I decline. I understand that services are provided on a voluntary basis and receipt of family planning services is not a prerequisite to receipt of any other services offered.

I understand that this consent to treatment will be in effect as long as I am seen at any of the APHCV clinic sites. I may cancel this consent in writing. The consent must be cancelled for each clinic that I am seen in.

B. AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS:

I authorize APHCV to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also APHCV may use and release any part of my medical records necessary to the process of billing third party payers for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to APHCV for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any APHCV account may be applied to my patient balance within the APHCV sites. A photocopy of this authorization shall be considered as effective and as valid as the original.

C. PROTECTED HEALTH INFORMATION DESIGNEE:

The individuals identified below are individuals I choose to be involved directly in *my care or my child's care.* I give permission to APHCV to communicate, discuss and release the patient protected health information related to the health care services I or my child receive at APHCV to this person(s). I understand that the information that can be released are limited to the following: Appointment/Procedure (scheduling, rescheduling, cancelling), Prescription re-fill(s), Laboratory test results, Radiology Examination Results, Referral Inquiries, Billing Inquiries.

Name of Designee: _____ Designee Date of Birth: _____

Designee Phone Number: _____ Relationship to Patient: _____

☐ I *decline to provide a protected health information designee contact for myself or my child at this time.*

Patient/Parent / Legal Guardian Signature **(← Please circle one)** _____Date: _____

D. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

- I acknowledge that I received the Notice of Privacy Practices from APHCV.
- You also have the right to request to be contacted at a different location or by a different method.

APHCV will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, please provide the contact information below:

_____

Street Address City State Zip code

Alternative Telephone: _____

X_____ _____

Patient/Parent / Legal Guardian Signature **(← Please circle one)** Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (Print name of **Parent or Legal Guardian**) Relationship

PLEASE LEAVE THIS PAGE BLANK

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
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PATIENT PAYMENT RESPONSIBILITY POLICY

1. Payment is expected d in full when services are rendered.

2. Medi-Cal and/or Medicare
If you have Medi-Cal and/or Medicare, please provide us with your current Medi-Cal and/or Medicare Card at each visit. If you have a share of cost, you will be asked to pay that amount at the time of service. **All co-pays, co-insurances, and share of cost are due at time of service**. If your Medi-Cal and/or Medicare claim is denied, you are fully responsible for the cost of the service.

3. Private Insurance
If you have private insurance that we can accept, please provide us with a copy of your insurance card at each visit. **All co-pays, non-cove re d services and deductibles are due at time of service**. If your health insurance claim is denied, you are fully responsible for the cost of the service.

4. Self Pay Patients
Full payment is due at time of service. We accept CASH, CHECKS, CREDIT/DEBIT CARDS. We offer a sliding fee discount and prompt payment incentive if you qualify. Please ask the Front Office staff for additional information.

5. LAUSD students at school-based health centers
Upon the agreement with Los Ange les Unified School District, APHCV shall not charge fees to pre K – 12 students accessing services at school based health centers. APHCV shall charge all other populations as appropriate.

6. Government Funded Programs
We offer several different government funded programs for which you may qualify. If you would like more information, please ask our Front Office staff. Fee for services out of the scope of benefit of government funded program is Patient's responsibility.

7. Sliding Fee Discount Programs
We offer Sliding Fee Discount Program (SFDP) where your fee maybe discounted based on your household income and number of individuals live in the household. You may not eligible or decline to participate at this time, but when you decide to apply or your financial situation changes, you can ask APHCV receptionist staff for the program and provide required documents.

Thank you for choosing us as your health care provider. Please let us know if you have questions or concerns. By signing below you acknowledge and accept our Patient Financial Policy.

X_____ Date _____

Signature of Patient or Responsible Party

X_____ Date _____

Signature of Co-Responsible Party

English: revised 02/07/2020

PLEASE LEAVE THIS PAGE BLANK

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
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Place Patient label here

PATIENT SAFETY AGREEMENT

At Asian Pacific Health Care Venture, Inc. (APHCV) we do our best to provide a safe place for our patients and visitors to get quality medical care. Therefore, we ask patients and visitors to agree to the following:

1. **RESPECT OTHER CLIENTS AND STAFF:** I promise to respect the privacy and personal safety of all clients and staff of the clinic. I understand that any form of violence or aggressive behavior such as yelling, shouting, hitting, pushing, etc. will not be tolerated. I shall not steal nor vandalize APHCV property (including graffiti).

2. **NO WEAPONS:** I and anyone who comes with me (friends or family) shall not bring weapons of any kind into the clinic area at any time. I understand that if I bring a weapon such as guns, knives, stun guns or any other type of weapon into the clinic I may be asked to leave. I may also be transferred to another facility for my care. If I am legally permitted to carry a weapon (e.g., if you are a peace officer) I shall tell the front desk when I check in.

3. **NO CRIMINAL ACTS:** I shall not do any criminal acts while at APHCV. I understand that APHCV holds right to report any illegal activities to the authorities.

4. **WATCH MY CHILDREN AND BELONGINGS:** I shall supervise and regulate any family members and visitors, in particular children, who may come with me to the clinic. I am also responsible in watching my belongings at all times.

5. **ACCEPTING CONSEQUENCES:** I understand the above responsibilities and will follow them to the best of my ability. I understand that the violation of the above expectations may result in refusal or termination of care at APHCV.

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
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Place Patient label here

PATIENT RESPONSIBILITIES

Asian Pacific Health Care Venture, Inc. (APHCV) and its staff work with patients in order for them to receive quality and effective medical care, to achieve this goal, we ask all patients to be informed and agree to the following patient responsibilities. **Please place your initials after reading each statement next to the provided space.**

1. **PROVIDE INFORMATION:** I shall provide true and complete information about my past and current illnesses, hospitalizations, medications and other matters relating to my health and answer any questions related to it, to the best of my knowledge. I shall provide up-to-date contact information so that APHCV has a way to contact me when it is necessary. Initial _____

2. **ASK QUESTIONS:** I shall ask questions about my health problems and treatment if they are not clear to me. Initial _____

3. **CALL FOR APPOINTMENT:** If I am not feeling well or have a question about my health care, I will call the clinic. If I feel that I need to come for medical, mental, dental care, case management, social services, or prescription refills, I will call first. If appointments are not available, I can still come to the clinic as walk-in. I understand that if I walk in, I may have to wait, and I might not get an appointment the same day. Initial _____

4. **KEEP MY APPOINTMENT:** I shall keep all my scheduled appointments and arrive on time. If I cannot keep my appointment, I will call the clinic and cancel my appointment at least 24 hours before my appointment time. I shall arrive about 20 or 40 minutes prior to my scheduled appointment, depending on my appointment and/or insurance program renewal if needed, to allow enough time to complete my check-in process. *I understand my appointment will be cancelled, re-scheduled or moved to another time if I arrive after my given scheduled check-in time*. Initial _____

5. **RESPONSIBLE FOR MY CARE:** I understand that I am ultimately responsible for my own health care and for that of my family. It is my responsibility to make and keep appointments for treatment of diseases or conditions and preventative care such as health check-ups, immunizations, pap smears, mammograms, or HIV tests. I understand that I am responsible for the outcomes if I do not follow the instructions of health care providers. Initial _____

6. **INDIVIDUALS WITH DISABILITIES USING SERVICE ANIMALS**: I understand that I am responsible for the care and supervision of my service animal at all times, which includes leashing, toileting, cleaning up and disposal of animal waste, feeding. I understand that APHCV may require a service animal to be removed from the clinic immediately if APHCV finds any of the following; (a) the service animal is disruptive, out of control; or (b) the service animal causes any harm to patients/staff. Initial _____

I have read, understood, and agreed to adhere to both the Patient Safety Agreement and the Patient Responsibilities.

_____ _____

Patient/Parent/Legal Guardian Signature **(Please circle one)** Date

_____

Print Name

(SBHC use only)

Parent verification by:

_____

Date: _____

ASIAN PACIFIC HEALTH CARE VENTURE, INC.

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Patient Identifying Label

Telehealth/Telephone Informed Consent

1. I agree to receive health care services via Telehealth/Telephone. I understand that:
    a. I have the right to access covered services through an in-person, face- to-face visit or through Telehealth/Telephone.
    b. The use of Telehealth/Telephone is voluntary, and I may withdraw my consent to, or stop receiving services through Telehealth/Telephone at any time without affecting my ability to access covered services in the future.
    c. My insurance provides coverage for transportation services to in-person services when other resources have been reasonably exhausted.
    d. There may be limitations or risks related to receiving services through Telehealth/Telephone as compared to an in-person visit. For example:
        - Telehealth/Telephone involves alternative forms of communication that may reduce video and/or audio quality comparing to in person face-to-face visit.
        - Telehealth/Telephone sessions could be disrupted, and medical evaluation or treatment could be delayed due to deficiencies or technical failures.
        - Information transmitted may not be sufficient (e.g., poor resolution of video, poor audio) to allow for appropriate medical decision making by the provider. Your provider may determine that telehealth and/or telephone service are not appropriate for certain evaluation/treatment.
        - Public devices and/or network that may be accessed by someone else other than yourself are not secure and should be avoided. It is strongly recommended to use a secure and/or private device and internet network.
        - A timely response to emergencies during Telehealth/Telephone session may be limited. If there is an emergency during a Telehealth/Telephone session, APHCV will contact emergency services and patient's emergency contacts if needed clinically necessary.
2. I have read this document carefully, understand the potential limitations and risks of receiving services via Telehealth/Telephone, and have had my questions answered to my satisfaction.

Signed: **X**_____ _____

Patient/Parent/Legal Guardian Signature **(Please circle one)** **Date**

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (Print name of **Parent or Legal Guardian**) Relationship

PLEASE LEAVE THIS PAGE BLANK

Patient Label

Open Payments Database Notice

English: Open Payments Database Notice

The Open Payment 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 **openpaymentsdata.cms.gov.**

Spanish: Aviso de la base de datos de Revelación de Pagos

La base de datos de Revelación de Pagos es una herramienta federal que se utiliza para rastrear los pagos realizados por compañías de medicamentos y dispositivos a médicos y hospitales docentes. Se puede encontrar en openpaymentsdata.cms.gov.

Thai: ขอแจ้งให้ทราบเรื่อง ฐานข้อมูลสาธารณะ เกี่ยวกับการชำระเงินให้ทางการแพทย์

ฐานข้อมูลสาธารณะ เกี่ยวกับการชำระเงินให้ทางการแพทย์ คือบริการของรัฐบาลกลาง เพื่อให้บุคคลทั่วไปสามารถค้นหาการชำระเงินที่ทำโดยบริษัทยาและอุปกรณ์ทางการแพทย์ ที่สั่งจ่ายให้แก่แพทย์วิชาชีพ และโรงพยาบาลที่สอนต่างๆ ซึ่งท่านสามารถเข้าไปค้นหาข้อมูลได้ที่หน้าเวบไซต์ openpaymentsdata.cms.gov.

Khmer: ប្រកាសបើកចំហរពត៌មានដែលតំកល់ទុក អំពីការទូទាត់ប្រាក់

ការបើកចំហរពត៌មានដែលតំកល់ទុក អំពីការទូទាត់ប្រាក់ គឺជាឧបករណ៍នៃសហព័ន្ធមួយដែលប្រើដើម្បីស្វែងរកការទូទាត់ប្រាក់ ដែលបានធ្វើឡើងដោយក្រុមហ៊ុនថ្នាំពេទ្យ និងក្រុមហ៊ុនឧបករណ៍ពេទ្យ ឱ្យដល់គ្រូពេទ្យ និងមន្ទីពេទ្យដែលបង្រៀន។ អាចរកឃើញនៅក្នុងវិបសាយ openpaymentsdata.cms.gov.

Bengali: পেমেন্ট ডাটাবেসের নোটিশ খুলুন

ওপেন পেমেন্ট ডেটাবেস হল একটি ফেডারেল টুল যা ঔষুধ এবং ডিভাইস কোম্পানির দ্বারা চিকিৎসক এবং শিক্ষাদানকারী হাসপাতালগুলিতে করা অর্থপ্রদান অনুসন্ধান করতে ব্যবহৃত হয়। এটি openpaymentsdata.cms.gov এ পাওয়া যাবে।

Japanese: オープンペイメントデーターベースのお知らせ

オープンペイメントデーターベースは製薬会社や機器会社が医師や教育病院におこなった支払いを検索するために使用される連邦政府のツールです。**openpaymentsdata.cms.gov.**でご確認いただけます。

Chinese: 打開支付數據庫通知

Open Payment Database 是一種聯邦工具，用於搜索藥品和設備公司向醫生和教學醫院支付的款項。它可以在 openpaymentsdata.cms.gov. 找到

Vietnamese: Mở thông báo cơ sở dữ liệu thanh toán

Cơ sở dữ liệu thanh toán mở là một công cụ liên bang được sử dụng để tìm kiếm các khoản thanh toán do các công ty dược phẩm và thiết bị thực hiện cho các bác sĩ và bệnh viện giảng dạy. Nó có thể được tìm thấy tại openpaymentsdata.cms.gov.

Signed: _____ Date: _____

Patient or Patient Representative

All sites: Effective 01/01/2023

PLEASE LEAVE THIS PAGE BLANK

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
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Notice of Privacy Practices related to Health Information Exchange Participation

Asian Pacific Health Care Venture, Inc. (APHCV) needs to inform patients of important changes in our privacy practice.

Health information exchanges. Health Information Exchange (HIE) is the electronic movement of health information between different healthcare organizations. It allows participating providers to securely access and share a patient's medical information including medication and diagnoses electronically. This can be lifesaving in an emergency. Such sharing is generally recommended by insurance companies for better coordination of care and services. You have a right to request to not share information. However, if you do not want us to share such information, it also may mean we may not able to find information about you when you go to a hospital. Sharing hospital information is not automatic.

APHCV may share information that we obtain or create about you with other health care providers or other health care entities, such as your health plan or health insurer, as permitted by law, through health information exchanges (HIEs) in which we participate. For example, information about your past medical care and current medical conditions and medications can be available to us or to your other primary care physicians or hospitals, if they participate in the HIEs as well. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions.

We may share information about you through HIEs for treatment, payment, health care operations, or research purposes. You may opt out of your information being accessible in or through the HIE(s) and disable access to your health information available through completing and submitting an Opt-Out form to APHCV by mail, fax or in-person. Even if you opt out of your information being generally accessible through the HIE(s), your health information relating to public health reporting and controlled dangerous substances information will still be available to providers through the HIE(s) as permitted by law. Your hospital or health care provider may also participate in other HIEs, including HIEs that allow your provider to share your information directly through our electronic medical record system.

If you would like to opt out from HIE participation, please contact the Front Office staff at the clinic to obtain the Opt-Out form.

I acknowledge that I received the above Notice of Privacy Practices related to HIE participation from APHCV.

X _____ _____

Patient/Parent / Legal Guardian Signature **(← Please circle one)** Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (Print name of **Parent or Legal Guardian**) Relationship