BRIGHTER BEGINNINGS
Every Family Matters

Antioch Downtown 512 West 5th Street, Antioch CA 94509 **Phone** 925-303-4780 **Fax** 888-927-0710
Antioch Lone Tree 3505 Lone Tree Way, Ste #1, Antioch, CA 94509 **Phone** 925-303-4780 **Fax** 888-927-0710
Richmond 2727 Macdonald Avenue, RIchmond, CA 94804 **Phone** 510-236-6990 **Fax** 888-927-0710

New Patient Registration Form

Please fill out completely and ask for help if you have questions.

Legal Last Name: ____ **Legal First Name:** ___________________

Date of Birth: D____/ M_____/Y_____ Preferred Name (Alias): _____________

Address: ____
Street City State Zip

Home Phone: _____________________________ **Cell Phone:** ____

Email: ____

What language are you most comfortable speaking? ❒ English ❒ Spanish ❒ Other: ___________

How well do you understand English? ❒ Very well ❒ Moderate ❒ Very little ❒ Not at all

Marital Status: ❒Single (Never Married) ❒Married ❒Divorced ❒ Widowed ❒ Domestic Partnership ❒ Significant Other (unmarried)

Are you of Hispanic, Latino or of Spanish ethnicity?: ❒ Yes ❒ No

Race (Check all that apply): ❒American Indian/Native Alaskan ❒Asian ❒Black/African-American ❒Native Hawaiian ❒Pacific Islander ❒White ❒Other________________ ❒ Decline to Specify

Social Security Number:___________________ ❒ Do not have

RESPONSIBLE PARTY (Person to receive any billing notices--if 17 yrs and under, this is a parent/guardian):

❒ Self **OR: Last Name:** ____ **First Name:**_________________ **MI:** ____

Relationship to Patient: ____________ **Phone Number:** (_____) _____-__________ **Date of Birth:** ____/_______/_________

Address (if different: ____
Street City State Zip

EMERGENCY CONTACT (This phone number should be different than the phone number listed for patient above):

Full Name: ____ **Relationship:** ________________________

Emergency Contact Telephone Number: (_____) _____-__________

INSURANCE/COVERAGE

Insurance Company Name: ____ **Subscriber ID:** _______________________

Insured Person: ❒ Self
OR Last Name: ____ **First Name:**_________________ **MI:** ____

Relationship to Patient: _______________________ **Date of Birth:** ____/_______/_________

PREFERRED PHARMACY:

Name:____________________________________ **Address:** ______________________________________

How did you hear about our clinic?

❒ Friend/Family Member ❒ Event, talked with clinic staff ❒ Walking by ❒ Google Search
❒Insurance Covered Provider Directory ❒ Radio ❒ Flyer ❒ Bus Ad ❒ Other _______________

If patient is 17 years of age or younger:

Are you a Minor seeking confidential services? ❒Yes ❒No **Are you an Emancipated Minor seeking services?** ❒Yes ❒No

Parent / Legal Guardian #2:

Last Name: _____________________________________ **First Name:**_________________ **MI:** ____

Relationship to Patient: ____________ **Phone Number:** (_____) _____-__________ **Date of Birth:** ____/_______/_________

Address (if different): ______________________________
Street City State Zip

Your answers to the following questions will help us best serve you and continue to provide services to our community. Like all of your health information, these replies will be kept confidential and protected.

In the past 2 years, have you or a dependent family member worked in agriculture as a seasonal laborer (do not move from town to town to work, but only work certain seasons in agriculture)?
❒ Yes ❒ No

In the past 2 years, have you or a financially dependent family member worked in agriculture as a migrant laborer (temporarily moved to another town to find work in agriculture)?
❒ Yes ❒ No

What is the patient's current housing situation?
- ❏ Rent
- ❏ Own
- ❏ Staying at a family member or friend's
- ❏ Hotel or motel
- ❏ Shelter
- ❏ Car
- ❏ Street, encampment, or outdoors
- ❏ Transitional Housing
- ❏ Permanent Supportive Housing
- ❏ Other: ______________________

Has the patient been homeless at any point in the last 12 months?
❒ Yes ❒ No

Is the patient a United States Military Veteran?
❒ Yes ❒ No

What is the patient's sexual orientation?:
- ❏ Lesbian, gay or homosexual (attracted to people of the same sex/gender)
- ❏ Straight or heterosexual (attracted to people of the opposite sex/gender)
- ❏ Bisexual
- ❏ Do not know
- ❏ Choose not to disclose
- ❏ Something else, please describe: ________________

What sex was the patient assigned at birth on the original birth certificate? (please select one)
❒ Female ❒ Male

What is the patient's gender identity? (please select all that apply)
❒Male ❒Female ❒Trans Man/Transgender Male
❒ Trans Woman/Transgender Female
❒ Genderqueer, neither exclusively male or female
❒ Choose not to disclose
❒Additional Gender or Other Category:___________________

What are the patients preferred pronouns?
❒ She/her ❒ He/Him ❒ They/Them ❒ Other:_______

Does the patient have a disability? ❒Yes ❒No

As a HRSA-grant funded Community Health Center, every year we are obligated to report our patients' income levels to the governing health care organizations. Your personal identifying information will be kept confidential.

----------------State your Household income below--------------

Household Gross Income: $_________________ ❒Weekly ❒Every 2 weeks ❒Twice a Month ❒Monthly ❒Yearly

☐ Decline to State

Household Size (you+spouse+number of children): ___________

☐ Decline to State

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made with our Billing Department. Although we will compile the necessary forms to file with your insurance company, it is the responsibility of the patient to dispute any services not covered by the insurance. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate amount.

A Sliding Fee Scale Discount Program is available. There is no cost to apply. Medical visit fee ranges start at $25 and vary depending on your household size and income.

Are you interested in the Sliding Fee Scale Discount Program? ❒ Yes ❒ No

NOTICE OF PRIVACY PRACTICES: Brighter Beginnings is committed to protecting your health information in compliance with the law. You can review the Notice of Privacy Practices available in the waiting room, by request, or by reviewing on our website: https://www.brighter-beginnings.org/

The Brighter Beginnings Notice of Privacy Practice states:
- That it is our obligation under the law to protect your information with respect to your personal health information.
- How we may use and disclose health information.
- Your rights related to your personal health information.
- Our rights to change our Notice of Privacy Practices.

- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to users and disclosures not described in this Notice.
- The contact information to get further information about our privacy practices.

I, hereby, acknowledge that I have been offered a copy of the Consent and Notice of Privacy Practices.

Patient or Guardian Full Name: ____

Signature of Patient or Guardian: ____ **Date:** ______________

Patient Consent

My initials at left and my signature below certify that I have been provided the full detailed documents for the listed consent forms and that I consent to the statement.

Initials	Consents
	Authorization for Treatment: I hereby authorize medical treatment for the name below at Brighter Beginnings.
	Rights and Responsibilities: I hereby acknowledge that I have received a copy of Brighter Beginnings Patient Rights and Responsibilities.
	Health Information Exchange: I hereby authorize Brighter Beginnings to access my electronic medical records from my health care providers and other health care organizations that also engage in the exchange of health information, including centralized pharmacy records.
	Vaccination Registry Consent: I hereby authorize Brighter Beginnings to exchange records with the California Immunization Registry (CAIR) for any administered immunization or Tuberculosis skin test.
	E-Prescribing and External Medication History I hereby authorize Brighter Beginnings to transmit my prescriptions electronically to the pharmacy that I delegate as my primary pharmacy provider, to have access to the external history of medication transactions, and to perform formulary and benefit transactions to confirm which drugs are covered.
	Notification in Case of Breach of Confidentiality I understand that Brighter Beginnings is required per HIPAA law to provide notice in the event of a breach of privacy of a patient's protected health information and that authorization of notification continues even if I terminate services with Brighter Beginnings.
	Limited HIPAA Waiver for Remote Services Some services may be provided outside of the Brighter Beginnings buildings through alternative means (i.e., by phone or electronically through online/virtual platforms). I understand that these services will be private and confidential and only those that I approve of will be able to listen or observe. I agree that I nor anyone else will not record the delivery of any services.
	Telemedicine Consent: Brighter Beginnings offers certain services by video or telephone for Primary Care and Behavioral Health Services. I understand that there are limitations and risks to these voluntary services. I understand that there is a cost to these visits. I understand that I have the right to request an In Clinic visit if preferred and revoke consent to telemedicine.

I understand that I have the right to revoke any consent at any time by sending a written statement to the Brighter Beginnings Family Health Clinics, Privacy Office, 2727 Macdonald Ave Richmond CA 94804. Unless revoked, this consent is valid until the expiration date listed below (if blank: consent expires after 1 year).

Patient's Name: ____ **Today's Date:**_________

Signature of Patient/Guardian: ________________________________ **Expiration Date:** _________

STAFF USE ONLY

Notice of Privacy Practices not Obtained

BRIGHTER BEGINNINGS
Every Family Matters

To be completed by BBFHC when a patient's signed Acknowledgement form is not obtained.
Please check the box that best applies. ☐ Individual refused to sign ☐ An emergency situation prevented us from obtaining the acknowledgement
Comment: ____

CANCELLATION, MISSED APPOINTMENT, AND LATE ARRIVAL POLICY

For Medical and Behavioral Health Appointments

We, at Brighter Beginnings Family Health Center (BBFHC), understand that sometimes you need to cancel your appointment and there are emergencies out of your control. If you are unable to keep your appointment, please notify us as soon as possible. To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. **If you are more than 15 minutes late for a visit, it may not be possible for your provider to see you that day.** Your Provider will decide if they can see you, based on their schedule that day. If they are able to see you, there may be a wait for you to be seen. If the provider cannot see you, we will work with you to reschedule the appointment.
2. If you are unable to keep a scheduled appointment, please call our office prior to your appointment so that we may care for someone else during that time. **Cancellations must be received 24 hours in advance.**
3. Failure to notify our office in advance, of the inability to keep an appointment, will be documented as a "No-Show" appointment.
4. **If you have 3 "No-Show/Missed" appointments within a 6 month time frame, you may be placed on a 3 month probationary period. After two "no shows" or late cancellations, you will be sent a final notice.** After a third "no show" or late cancellation, **we will only be able to see you on a same day, space-available basis.**

I have read, received a copy, and understand this policy.

____

Signature of Patient or Guardian **Print Name** **Date**

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

I authorize that Brighter Beginnings can communicate with me regarding my treatment via electronic communications (please check one box):

☐ **I give permission to contact me by email and text message**
☐ **I give permission to contact me by email only**
☐ **I give permission to contact me by text message only**
☐ **Please do not contact me by email or text message**

I understand that this means Brighter Beginnings and/or my treating providers will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties. For this reason, it is recommended that any highly confidential communications take place in person, via telephone or via US Postal Service in order to protect your confidentiality.

This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I understand that I may revoke this authorization by providing written notice to Brighter Beginnings at 2727 Macdonald Ave Richmond, CA 94804.

I hereby authorize the transmission of my protected health information electronically as described above.

Signature of Patient or Guardian	**Print Name**	**Date**

BRIGHTER BEGINNINGS
Every Family Matters

NOTICE OF ACKNOWLEDGEMENT: ADVANCED DIRECTIVE

Note: This form is only completed by adults 18 and older and emancipated youth.

An Advance Directive is a legal document allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if he or she should lose decision making capacity. Advance Directives are the following written instruments: The Living Will and The Durable Power of Attorney for Health Care.

The Living Will
Any adult person may, at any time, make a written declaration directing the withholding or withdrawal of life-sustaining procedures in the event such person should have a terminal and irreversible condition or is in a continual, profound comatose state with no reasonable chance of recovery.

The Durable Power of Attorney
Any adult person may, at any time, through execution of a Durable Power of Attorney, designate another person to make treatment decisions for him/her in the event such person is usable to participate actively on his /her own behalf.

Please read the following statements:

- I have been informed of my rights to formulate Advanced Directives.
- I understand Brighter Beginnings can provide me with an Advance Directive form.
- I understand that I am not required to have an Advanced Directive in order to receive medical treatment at Brighter Beginnings.

Please check the appropriate answer and sign below:

☐ **I HAVE** executed an Advanced Directive.

Type: ☐ Living Will ☐ Durable Power of Attorney

☐ **I HAVE NOT** executed an Advance Directive.

By signing this form, I acknowledge Brighter Beginnings has provided me information on Advance Directives.

Signature of Patient or Guardian	Print Name	Date

BRIGHTER BEGINNINGS
Every Family Matters