Vida Care
Medical Center

PATIENT REGISTRATION

If the patient is not completing this form, the person filling it out is _____, the

☐ Parent ☐ Legal Guardian ☐ Legal Representative of the patient.

Patient Name: First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____(MM) _____(DD) _____(YYYY)

Address:_____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersexual ☐ Decline to disclose

Ethnicity: ☐ Hispanic or Latino. ☐ Not Hispanic or Latino. ☐ Decline

Race: ☐ White ☐ Black or African American. ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ American Indian

☐ Other ☐ Declined

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Occupation: ☐ Full-Time Employee ☐ Part-Time Employee ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Active Military

Employer Name: _____ Work Phone: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Relationships to patient: _____

Consent to disclose medical information to Emergency Contact: ☐ Yes ☐ No

DISCLOSURE TO FAMILY MEMBERS AND/OR FRIENDS

I authorize the sharing of my Protected Health Information (PHI) to communicate results, findings, and care decisions with the family members and individuals listed below.

Name	Relationship	Phone Number

I have a: ☐ Living will ☐ Advanced Directives ☐ DNR ☐ Power of Attorney ☐ None ☐ Refuse

Legal Guardian/Caregiver: _____ Contact Phone: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone Number: _____

Insurance Address: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Responsible Party: ☐ Self ☐ Guarantor ☐ Check here if information is same as patient

Responsible Party Name (Last): _____ (First): _____(MI): _____

Guarantor Date of Birth: ____(MM) ____(DD) _____(YYYY)

Address: _____ Primary Phone: _____

By signing below, I certify all information above is true and correct to the best of my knowledge.

Patient or Patient's Legal Representative: _____ **Date:** _____

FINANCIAL POLICY

_____**(Initials)** The healthcare providers at Vida Care charge for the services they provide. These fees may differ from the initial estimate, including any applicable deductibles and coinsurances. Copayments are due at the time of service. Additionally, you are responsible for any deductibles and coinsurances associated with your insurance plan.

If your health insurance provider does not fully cover the charges for services provided by Vida Care, you (the patient or responsible party) are responsible for paying the outstanding amount not covered by insurance. This also applies to patients in their grace period.

If the insurance information you have provided to Vida Care is incorrect, you may be required to pay for the services rendered. If you do not have health insurance, you will be required to pay for the medical services you receive.

Medicare will only pay for the care that is acceptable and needed under section 19862(a)(1) of the Medicare Law. By signing below, you certify the facts you have given to Vida Care for payment under Tittle XVIII and XIX of the Social Security Act are correct.

_____**(Initials)** I authorize Vida Care to submit claims to my health insurance company for the services I receive. I understand that payments will be made directly to Vida Care on my behalf.

Patient or Patient's Personal Representative: _____ **Date:** _____

CONSENT TO TREATMENT

_____**(Initials)** By signing below, I give my consent to receive medical care and treatment from Vida Care healthcare providers.

_____**(Initials)** I understand that the treatment and services provided may include laboratory tests, routine exams, screening tests to detect early signs of illness, and diagnostic tests to identify specific health conditions.

_____**(Initials)** I understand that no guarantees have been made regarding the outcomes of my treatment or services.

_____**(Initials)** I acknowledge that Ihave the right to refuse any treatment or procedure and that Imay discuss all medical options with my healthcare provider before proceeding.

_____**(Initials)** I confirm that I have read and understood the provisions outlined above. I've had the opportunity to ask questions, and by signing this form, I consent to the terms described, both individually and collectively. A copy of this form is acceptable in place of the original.

____**(Initials)** Consent for Treatment of Minor or Incapacitated Patient. As the Personal Representative,I authorize Vida Care to provide necessary medical care, including emergency treatment, to the minor or incapacitated patient.

Patient or Patient's Legal Representative: _____ **Date:** _____

PATIENT HIPAA ACKNOWLEDEMENT & HEALTH INFORMATION EXCHANGE OPT-IN

___**(Initials)** I acknowledge receipt of the Notice of Privacy Practices (www.vidacare360.com) which outlines my rights and Vida Care's responsibilities regarding my protected health information (PHI). The notice specifies that Vida Care is authorized to use, disclose receive, and exchange my PHI for (I) treatment, payment, and healthcare operations purposes; (II) as authorized by me in writing; and (III) as permitted under the regulations of the Health Insurance Portability & Accountability Act (HIPAA) and (www.vidacare360.com) with any questions or complaints. To the extent permitted by law, I voluntarily consent to the use, disclosure, receipt and exchange of my PHI for the purposes described in the Notice of Privacy Practices.

___**(Initials)** Health Information Exchange. I understand that Vida Care participates in one or more health information exchanges (HIEs),which allow my healthcare providers to access my medical records quickly to improve the effectiveness and efficiency of my treatment. (https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/health-information-exchange).
Through HIEs, Vida Care Medical Center is able to share, request and/or access health information from my electronic medical record(s) for Permitted Uses.
I agree that if I do not want my health information electronically shared, requested and/or accessed through HIEs, I may opt-out at any time by completing an HIE Opt-Out form obtained from Vida Care Medical Center location or website (www.vidacare360.com).
I understand that my participation in HIEs is voluntary and not requires to receive treatment or care at Vida Care. My authorization will remainin effect until I revoke it. Any revocation will not apply to my health information that has previously been shared, requested and/or accessed through HIEs for Permitted Uses.

Patient or Patient's Legal Representative:_____ **Date:** _____

CONSENT FOR COMMUNICATIONS

__**(Initials)** By providing my phone number and email address, I voluntarily authorize Vida Care to contact me using automated or autodialed phone calls, prerecorded messages, artificial voices, voicemail, automated SMS messages, and email. These communications may include treatment-related information, as well as marketing materials about healthcare products and services recommended by Vida Care. I understand that these communications may not be encrypted or secure, and while Vida Care will implement appropriate safeguards to protect my protected health information (PHI) in accordance with HIPAA and applicable laws, I acknowledge that there may be risks associated with electronic communication. I also understand that message and data rates may apply.

I acknowledge that I have the right to opt out of receiving future Vida Care communications at any time by using the provided opt-out option. Iunderstand that Imay revoke my consent at any time by completing a new patient registration form or by notifying Vida Care in writing. I understand that signing this consent is not arequirement for receiving treatment or services from Vida Care, and opting out will not affect my access to care. I confirm that I own/control the phone number and email address I have provided, and I agree to notify Vida Care in writing within thirty (30) days if I change my phone number or email address.

____ (Initials) I acknowledge and agree to receive communications related to my treatment and care from Vida Care, which may occur multiple times per day, and/or outside the hours of 8:00 AM to 8:00 PM, as needed, and may exceed any applicable legal limitations.

Patient or Patient's Legal Representative: _____ **Date:** _____

PHOTO IDENTIFICATION (if applicable)

For the benefit of its patients, Vida Care has implemented a process that uses photographs for patient identification and authentication purposes. I authorize Vida Care to take a photograph of me (or the person I represent as a Personal Representative) for use in identifying and authenticating me during patient registration, check-in, and throughout the duration of my visit. I understand that my photograph will only be used for these purposes, stored in my electronic medical record in accordance with HIPAA and relevant laws, and will not be shared with third parties without my consent, except as required by law.
I acknowledge that providing a photograph for identification/authentication is voluntary, and I have the right to revoke my authorization and opt out of this process at any time by notifying Vida Care in writing. I also understand that choosing not to participate will not affect my treatment or services available to me at Vida Care. If I choose not to have my photograph taken, I will be asked to provide photographic identification at each visit.

Patient or Patient's Legal Representative: _____ **Date:** _____

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND

FULLY UNDERSTAND ALL OF THE INFORMATION CONTAINED IN THIS DOCUMENT.