LA CLINICA

AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

Please complete this form so that we can accurately qualify you and your family for our grant programs

Patient's Full Name_____ DOB_____

Email address _____ SSN_____

If Patient is a minor:

Mother's Name_____ Father's Name _____

Are you a Veteran? ☐ Yes ☐ No

Are you disabled? ☐ Yes ☐ No

Please select your ethnicity: ☐ Hispanic ☐ Non-Hispanic

Please select your race:

☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Native Hawaiian

☐ Pacific Islander ☐ Caucasian ☐ Black

Have you or anyone else in your household worked in any of the following industries in the last two years? (Check all that apply)

☐ Orchards ☐ Crops/Harvesting ☐ Reforestation/Tree Planting

☐ Vineyards ☐ Packing House ☐ Fertilizing/Turning of Soil

If you checked any of the above boxes, did your work ever require your family to move? ☐ Yes ☐ No

La Clinica is able to help our patients offset the cost of health services due to grant support from the government. As a result, we are required to gather income and household information for each of our patients. We realize this is very personal information and we will continue to protect your confidentiality with this information as well as with your personal health information.

Current Employer _____ Position _____ Work Phone _____

Are you and your family members living in someone else's household? ☐ Yes ☐ No

In the past 24 months, have you or someone in your household lived in one of the following: shelter, group home, recovery center or jail? ☐ Yes ☐ No

In the past 24 months, have you and your family been forced to move into a temporary situation because of housing costs? ☐ Yes ☐ No

Please list all members currently living in your household:

Name	Relationship	Age	Insured?
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N

If you need additional space, please use reverse side.

MRN_____ Rev 06/11

LA CLINICA
SCHOOL-BASED HEALTH CENTERS

541-842-3771 http://laclinicahealth.org/school

Student name_____ **Birthdate**_____ **Sex - M/F**_____ **Race**_____
MM/DD/YYYY

Home address_____ **City**_____ **ZIP**_____

Home phone_____ **Work or message phone** _____ **Is your child disabled?** Y / N

INCOME AND INSURANCE INFORMATION
No one is turned away for inability to pay

How many people are in your family? _____ Are you a single parent? Yes ☐ No ☐ If yes: Male ☐ Female ☐

Please list your family's annual income range (we can offer discounts in some cases, and this will help us determine if you are eligible):

☐ **0-$30,000** ☐ **$30,001-$40,000** ☐ **$40,001-$50,000** ☐ **$50,001-$60,000** ☐ **$60,001-$70,000** ☐ **$70,001-$80,000** ☐ **$80,000 and over**

☐ **My child has medical insurance (please provide a copy of your card)**

☐ **My child has NO medical insurance** ☐ **I need help with Oregon Health Plan (Medicaid) enrollment**

Name of primary insured_____ DOB _____

Insurance company _____ ID# _____ Group#_____

Insurance address _____

Have you or anyone in your household worked in any of the following during the last two years? Please check all that apply:
☐ Orchards ☐ Packing house ☐ Reforestation/tree planting ☐ Vineyards ☐ Crops/harvesting ☐ Fertilizing/turning of soil

In the past 24 months have you or someone in your household lived in one of the following situations: on the street or in a shelter, abandoned building or vehicle, transitional housing, recovery center, group home, or in any other temporary situation? Y / N

In the past 24 months have you and your family been forced to stay with friends or extended family or have you moved to temporary housing because of housing costs? Y / N

MEDICAL INFORMATION

Does your student have a doctor/family nurse practitioner he or she sees regularly? **Y / N** If yes, name _____

List known **allergies** (medications/foods/other) _____

What medication does your child take regularly _____

History of other medical problems _____

I give permission for my child (listed above) to receive over the counter medications (e.g. Tylenol, Advil, etc.) for symptom relief, even in the event that I cannot be notified. Yes___ No ___ *Parent/guardian initial:*_____

As the custodial parent and/or legal guardian for the child listed above, my signature on this form allows my child to receive services at any La Clinica school-based health center. I understand that La Clinica will bill my medical insurance for eligible visits. I agree that I have given full, complete, and accurate information. I understand this consent will remain in effect for seven years or until revoked verbally or in writing. I agree to provide updated information as requested.

Signature _____
Signature of Parent/Guardian **Relationship to Student** **Date**

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MRN:	PCP:	DATE:

Medical Consent Form

Authorization for Medical Treatment and Participation in Patient-Centered Care

What is patient-centered care? This phrase is used as part of Oregon's Patient Centered Primary Care Home program and simply refers to care that is focused on the needs of patients. Clinics recognized as Patient Centered Primary Care Homes notify patients of the approach as part of the designation.

Under patient-centered care, your primary care provider will work with you to improve your health and to coordinate your care with other providers. For example, your primary care provider could connect you with a health coach, a nurse, a nutritionist, or another type of provider. This is called your "health team," and your primary care home is at the center, making sure you have all the information you need.

Your La Clinica provider and team will encourage and support you as you become involved in your care. Our goal is to ensure that your healthcare needs are met so that you have the best possible health outcomes, and that you and your family receive the care you need, when you need it.

I authorize the medical staff of La Clinica to administer to _____ such treatment as they deem
Patient Name
necessary for the patient's benefit. I also authorize the use of anesthetics and/or medications. I acknowledge that no guarantee or assurance has been made relative to the results that may be obtained.

I understand the model of care provided at La Clinica and I agree to enroll myself in La Clinica's Patient Centered Primary Care Home.

Authorization of Payment

I assign and authorize direct payment to La Clinica of all insurance and plan benefits that are payable for service(s) I receive and also authorize release of any medical records necessary to facilitate my treatment to process claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

Notice of Privacy Practices

I acknowledge receipt of La Clinica's Notice of Privacy Practices. This notice is provided the first time I receive services from La Clinica and is otherwise available to me at any time upon request.

Patient Rights and Responsibilities

I acknowledge receipt of La Clinica's Patient Rights and Responsibilities.

Consent to Photograph for Electronic Health Records

I authorize La Clinica to take my photograph to be stored in my electronic health record. This photograph will be used to identify me and help protect me against identity theft.

Patient Signature	Date	Witness

If patient is a minor:

Parent or Guardian	Date	Relationship to Patient