

CHILD'S NAME: _____ DATE OF BIRTH: _____

PARENT/GUARDIAN NAME(s): _____ DATE: _____

Which health center do you prefer? ☐ Grass Valley ☐ Penn Valley ☐ Auburn ☐ Kings Beach ☐ Downieville

The information requested below will help us to provide better care for your child. Please take time to answer all appropriate questions. We will review the information with you to fill in details. Thank you!

1. Are there any special concerns about your child's health now? Yes ☐ No ☐
2. Does your child take any medications at this time? Yes ☐ No ☐
3. Your child's birth weight: _____ Was he/she born at full term? Yes ☐ No ☐
4. Were there complications during your pregnancy with this child? Yes ☐ No ☐
(e.g. infections, use of drugs, medications)
5. Was the labor or delivery complicated? Yes ☐ No ☐
(e.g. Cesarean delivery, breech position, baby needing oxygen)
6. Did your child have problems as a newborn? Yes ☐ No ☐
(e.g. jaundice, breathing trouble, infection)
7. Has your child ever been hospitalized? Yes ☐ No ☐
8. Has your child ever had surgery? Yes ☐ No ☐
9. Has your child had serious injuries? Yes ☐ No ☐
10. Has your child had other medical problems? Yes ☐ No ☐
11. Is your child allergic to anything (e.g. to medications)? Yes ☐ No ☐
12. Are your child's vaccines up-to-date? Yes ☐ No ☐
13. Have there been any unusual reactions to vaccines? Yes ☐ No ☐
14. Have you ever felt that your child's growth or development were faster or slower than other children at the same age? Yes ☐ No ☐

In the family (including the mother's and the father's families), are there any of the following?

1. Allergy problems or asthma Yes ☐ No ☐
2. Deafness Yes ☐ No ☐
3. Diabetes requiring insulin Yes ☐ No ☐
4. Cystic Fibrosis Yes ☐ No ☐

- | | | |
|--|------------------------------|-----------------------------|
| 5. Infant deaths | Yes ☐ | No ☐ |
| 6. Intellectual disability | Yes ☐ | No ☐ |
| 7. Strokes or heart attacks
(Before age 50 in males or 60 in females) | Yes ☐ | No ☐ |
| 8. High blood cholesterol | Yes ☐ | No ☐ |
| 9. High blood pressure | Yes ☐ | No ☐ |
| 10. Other medical problems in the family | Yes ☐ | No ☐ |

Mother and Father are: Married ☐ Separated ☐ Divorced ☐ Remarried ☐

Mother's occupation:

Father's occupation:

Who lives in your child's household?

Are you concerned about your child's behavior at this time? Yes ☐ No ☐

Please check any of the following symptoms that have been present in the last year:

- | | |
|---|---|
| ☐ Weight loss or change of appetite | ☐ Recurring fevers without explanation |
| ☐ Severe headaches | ☐ Frequent constipation |
| ☐ Chronic cough or trouble breathing | ☐ Vision, hearing, or speech problems |
| ☐ Muscle weakness | ☐ Joint pain, swelling, or limp |
| ☐ Recurring abdominal pains | ☐ Unusual skin rashes |
| ☐ Painful or excessive urination | |

Other complaints or concerns?

Nutrition (please leave blank):

Parent/Guardian Signature: _____ Date: _____

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PATIENT INFORMATION				
First Name	Middle Name	Last Name	Other Name	
Physical Address		City	State	Zip
Mailing Address		City	State	Zip
Home Phone ☐ Text Enabled	Work Phone		Cell Phone ☐ Text Enabled	
☐ I give WSMC permission to leave detailed messages concerning my care on my voicemail. Number:				
Date of Birth	Social Security #	Email Address	☐ Create Patient Portal Account	
Emergency Contact	Emergency Contact Phone		Relationship to Emergency Contact	
Name of Father/Guardian:		Name of Mother/Guardian:		
Is anyone else authorized to bring your child in for a visit? If so, Name and Relationship to Patient: _____ Does this person have legal authority to consent to treatment and receive protected health information pertaining to your child? ☐ Yes ☐ No		Is there anyone with whom you want us to share protected health information pertaining to your child? If so, Name and Relationship to Patient:		
Patient Race: ☐ Japanese ☐ Native Hawaiian ☐ Black/African American ☐ Asian Indian ☐ Korean ☐ Other Pacific Islander ☐ American Indian/Alaska Native ☐ Chinese ☐ Vietnamese ☐ Guamanian or Chamorro ☐ White ☐ Filipino ☐ Other Asian ☐ Samoan ☐ Unreported			Patient ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report	
Sexual Orientation: ☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Choose not to disclose ☐ Don't know		Gender Identity: ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Choose not to disclose ☐ Other		
Birth Sex: ☐ Male ☐ Female				
Are you a Veteran? ☐ Yes ☐ No	Are you a migrant farm worker? ☐ Yes ☐ No	Are you homeless?*	How did you hear about WSMC?	
Primary Language		Family Size (household)	Annual Income (household)	
Date of Injury/Onset of Illness:	Are you here for an automobile accident? ☐ Yes ☐ No	Are you here for a work-related injury or illness? ☐ Yes ☐ No	Are you pregnant? ☐ Yes ☐ No	
Please explain the reason you are here today:				
Primary Care Provider (PCP): Note: You must follow up with your PCP after each urgent care visit		Primary Care Provider Phone		
*To be considered homeless, you must fit into one of the following categories: - Lacking a regular, adequate place to sleep at night. - Losing your primary nighttime residence within 14 days and not having an alternative. - Being an unaccompanied youth under 25 or part of a family with children who qualify under other Federal statutes. - Fleeing domestic violence and lacking permanent housing resources or support networks.				

GUARANTOR – PERSON RESPONSIBLE FOR PAYMENT			
☐ Mr. Last Name First Name Middle ☐ Mrs. ☐ Miss	Relationship to Patient	Home Phone ()	
Billing Address (if different from Patient's) City		State	Zip Code
Employed By	Job Title/Department	Work Phone Ext. # () ()	
Employer Address (Number and Street)	Guarantor's Social Security # -- --	Guarantor's Date of Birth	
City	State	Zip Code	

PRIMARY INSURANCE INFORMATION		
Insurance Company	Policy Number	Group Number
Subscribers First Name	Subscribers Middle Name	Subscribers Last Name
Date of Birth	Social Security #	Employer

SECONDARY INSURANCE INFORMATION		
Insurance Company	Policy Number	Group Number
Subscribers First Name	Subscribers Middle Name	Subscribers Last Name
Date of Birth	Social Security #	Employer

PHARMACY CHOICE
☐ WSMC Pharmacy Located at 844 Old Tunnel Road in Grass Valley ☐ Other: Pharmacy Name: _____ City: _____

CONSENT FOR MEDICAL TREATMENT
The undersigned, as the above patient or as the parent, legal guardian or legal representative of the above patient, hereby consents to medical treatment of the above patient by Western Sierra Medical Clinic (WSMC) and its medical providers and clinical staff. Treatment may include any necessary examination, test or medical procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient to be performed by WSMC clinical staff. I understand and acknowledge this authorization is given in advance of any specific diagnosis, treatment or procedure being required to provide specific consent to any and all such diagnosis, treatment or procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient. I understand the above patient may ask questions and have all questions answered and also may refuse treatment at any time. If the above patient is seeking substance abuse testing, I authorize WSMC to obtain a specimen pursuant to proper medical protocol to determine the presence of drugs or alcohol. I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of the above patient's personal physician.

HEALTH INFORMATION EXCHANGE

Electronic Health Information Exchange (HIE) allows doctors, nurses and other health care providers to access and securely share a patient's vital medical information electronically, improving the speed, quality, safety and cost of patient care. Electronic health information systems can help prevent errors by ensuring that everyone involved in a patient's care—whether in a primary care setting, a specialists' office or emergency department—has access to the same information. HIE helps facilitate coordinated patient care, reduce duplicative treatments and avoid costly mistakes. This practice is growing among health providers because the need for HIE is clear and the HIE benefits are significant.

By default, all patients are "Opted In" in the HIE, meaning that once notified of the HIE, a patient must complete an Opt Out form if they do not wish to participate. A patient's health information will be available to all of the providers in the system who need it to provide care WITHOUT having to sign any further forms. Please see the receptionist if you would like a copy of this form or would like to request a change to your HIE options.

TELEMEDICINE

At WSMC, we offer telemedicine services as a convenient way to receive medical care through phone or video consultations. This method is cost-effective, saves time, reduces transportation barriers, and improves access to healthcare. Studies have also shown that telemedicine can improve the quality of healthcare.

However, it's important to note that telemedicine does have limitations. Telemedicine requires adequate privacy, technology, and service to conduct phone calls or video visits. In some circumstances, it may not be appropriate for conditions that require a physical examination.

Telemedicine visits costs can vary by insurance, however, the visit cost for telemedicine is no more than a standard office visit. You have the right to request more information about our telemedicine services. You may deny telemedicine visits and request an in-office consultation at any time during the scheduling process.

FINANCIAL RESPONSIBILITY

It is the patient's responsibility, and the responsibility of a patient's parent/legal guardian, to pay their share of charges for services provided by WSMC at the time of service, unless other arrangements are made in advance in writing signed by the patient and an authorized WSMC staff member. Payment of a patient's share can be in the form of insurance copays, deductibles, or cash payment for uninsured patients and cash pay patients. Patients not enrolled in health plans are responsible to pay for the entire amount of their bill. Patients enrolled in health plans are responsible for any amount the plan does not pay, up to the entire amount.

WSMC accepts cash, checks, and most major credit cards. A \$25.00 fee will be charged for the first check returned by the bank and a service fee of up to \$35 for each subsequent check returned by the bank to that same payee.

WSMC does not accept liens or other forms of promised payments for patients who are involved in work-related or personal injuries (e.g., automobile accidents). Patients pursuing claims for work-related or personal injury should consult with their employer and/or the appropriate insurance company for health care needs. WSMC will provide primary care services to a patient pursuing these claims as requested by the patient, but the patient remains responsible to pay for all such services in full. WSMC will not bill workers compensation, automobile or other similar insurance company.

IDENTITY AND INSURANCE VERIFICATION

Patients are required to provide WSMC with correct insurance information and to verify current personal information (home address, employer, phone number, insurance cards, and photo ID) at the each appointment check-in. It is important that you bring proof of insurance each time you visit. Failure to do so may result in you not being seen or being required to make a full payment at the time services are rendered.

WILLINGNESS TO PAY

No one will be denied services at WSMC due to inability to pay as long as there is a "willingness" to pay. Willingness to pay means either paying for services rendered (either through insurance with payment of patient copays and deductibles, cash pay, sliding fee scale) or a commitment to follow a written payment plan in order to pay off any outstanding balance in accordance with WSMC's policies and procedures.

An unwillingness to pay is demonstrated by a patient when the patient refuses to pay for services rendered (including copays, deductibles, and fees owed under the sliding fee scale discount program), refuses to commit to a written payment plan, or refuses to comply with a written payment plan signed by the patient.

Uninsured Patients needing financial assistance to pay for services should fill out a sliding fee scale application (see below) and may seek assistance from staff.

If a patient signs a written payment plan and has difficulty making payments under the plan, WSMC's Billing Department Supervisor is available to discuss amending the payment plan.

SLIDING FEE

For patients who qualify, a sliding scale discount may be applied to a patient's initial primary care, dental or behavioral health visit and for visits over the following six months. Patients who desire to apply for a sliding fee discount are required to complete an application, which explains WSMC's sliding fee scale discount program. Please ask a WSMC Billing Department staff member for the application and for an answer to any question regarding the sliding fee scale discount program.

ASSIGNMENT OF BENEFITS

I hereby irrevocably assign and/or convey directly to Western Sierra Medical Clinic, Inc. and/or its contracted healthcare providers (hereinafter "WSMC"), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by WSMC for treatment/services rendered by WSMC, regardless of its managed care network participation status. This Assignment of Benefits shall apply to all insurance coverage, including but not limited to the Centers for Medicare and Medicaid Services, its intermediaries, carriers or administrative contractors, State Medicaid programs, or any other governmental or commercial insurance. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. This assignment is valid until revoked in writing. A photocopy of this assignment is to be considered valid, the same as if it was the original.

ACKNOWLEDGEMENTS

1. WSMC's notices, policies, and procedures are subject to change without notice. By receiving services at WSMC, I am subject to those changes unless I indicate in writing that I do not accept the changes. I may request copies of the current notices, policies and procedures.
2. WSMC's Notice of Privacy Practices is posted in the lobby of each WSMC facility and on the WSMC website. A copy can be furnished to me upon request. I read and understand WSMC's Notice of Privacy Practices.
3. WSMC's Patient Rights and Responsibilities is posted in the lobby of each WSMC facility and on the WSMC website. A copy can be furnished to me upon request. I read and understand WSMC's Patient Rights and Responsibilities.
4. As a patient of WSMC, I have access to a medical provider 24 hours a day, seven days a week.
 - a. To access a medical provider after hours, call (530) 274-9762.
5. I may voice any concerns or grievances by contacting WSMC's Patient Advocate at (530) 274-9762 ext. 251.
6. I may not record, photograph or videotape inside a WSMC site.
7. I am solely responsible for safeguarding and protecting my personal property. WSMC is not responsible for safeguarding or for the theft, loss or damage to my personal property. I release all claims against WSMC for loss, theft or damage to my personal property.

SIGNATURE

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Signature or person giving consent or legal representation

Date

Print Name: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

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Western Sierra Medical Clinic (WSMC) is committed to providing quality of care to our clients and their families. We encourage patients to be aware of their rights and responsibilities as listed below:

You Have the Right to:

1. Receive considerate, respectful, and culturally appropriate care based on professional standards of practice.
2. Receive services without discrimination on the basis of race, color, sex, marital status, religion, age, handicap, sexual orientation or preference, national origin, ancestry or diagnosis.
3. Establish advance directives and participate in ethical decision making.
4. Receive an explanation of your diagnosis, treatment, and prognosis in terms and language you can understand.
5. Receive the necessary information to participate in decisions about your care and to give your informed consent before any diagnostic or therapeutic procedure is performed.
6. Refuse any treatment, except as prohibited by law, and to be informed of the consequences of making this decision, which may include informing Children, Youth, and Family Services or Protective Services.
7. Expect that your personal privacy will be respected by all staff.
8. Expect that your medical records will be kept confidential and information will be released only with your written consent, in cases of medical emergencies, or in accordance with law.
9. Know WSMC policy for accessing and disclosing information in your medical records and reviewing your medical record, upon request, at a mutually designated time.
10. Receive a full explanation of any research or experimental procedure proposed for treatment and the opportunity to give your informed consent before any procedure will begin.
11. Know the name and qualification of all individuals providing service and how to contact that person.
12. Obtain another medical opinion prior to any procedure.
13. Have your legal custodian access your written medical records by appointment.
14. Ask for and receive information on your financial liability and an explanation of charges, including services that will be charged to your insurance.
15. File a complaint about services rendered without fear of discrimination from Western Sierra. Please call our Office Manager at (530) 274-9762 between 8:30 a.m. and 4:30 p.m.

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You are Responsible for:

1. Providing accurate personal, financial, insurance and medical information, including all medications and treatments, necessary to establish and follow your plan of care.
2. Asking questions if you do not understand the explanation of your diagnosis, treatment, prognosis or any instructions.
3. Informing WSMC of any requirements or accommodations needed to meet your cultural and/or language needs.
4. Following rules and regulations that are posted within WSMC while in the facility.
5. Not carrying any type of weapons when receiving treatment.
6. Not harming or being abusive to other persons including WSMC staff.
7. Keeping all scheduled appointments, arriving on time, and being able to participate in treatment.
8. Notifying WSMC with 24 hours' advance notice or as soon as you are aware that you cannot keep an appointment.
9. Informing WSMC health care professionals regarding any changes or reactions to medication and/or treatment.
10. Paying for services promptly including co-payments and total of cash charges at the time of service.
11. Advising WSMC of any problems or dissatisfaction with the service being provided.
12. Extending to WSMC staff the same courtesy given to you.
13. Developing and participating in your treatment planning.
14. Providing for the supervision and safety of your children while in the facility.
15. Keeping WSMC apprised of your current contact information.
16. Not videotaping or recording any WSMC staff.

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1	Patient's Last Name	Patient's First Name	Date of Birth
2	☐ Please release information/send records FROM WSMC* (To Person/Facility Below) ☐ Please release records TO WSMC (From Person/Facility Below) *Transferring your primary care outside of WSMC may delay your appointment for specialty care.		
3	Full Name of Organization/Provider/Individual (or Self)		
	Address		City
	State	Zip	Phone # with area code
	Fax with area code		
	Transmit: Verbally ☐ Electronic: ☐ Fax ☐ U.S. Mail: ☐ CD ☐ Paper		
4	CHOOSE ONLY ONE (1) Per Release ___ Medical ___ HIV/AIDS Testing & Treatment ___ Alcohol/Substance/Drug Use Treatment ___ Dental ___ Behavioral Health ___ Psychotherapy Notes ___ Other:		
5	Time Frame: ☐ Last Visit ☐ Past Year ☐ All ☐ Other:		
6	☐ All records ☐ Just these:		
7	Reason for release: ☐ Personal ☐ Transfer of Care ☐ Other:		
Authorization	By signing, I authorize use/disclosure of my health information and understand that: - I may revoke this authorization at any time by contacting WSMC in writing. - This authorization is valid for 1 year maximum or this earlier date: ___ / ___ / ___. - The recipient of your health information may not further disclose your information without obtaining another authorization from you. - All Alcohol & Substance Abuse health information is protected and only releasable with a separate express written consent of the person it pertains to. - My treatment/eligibility of care is not based on this authorization. - This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original - I have the right to a copy of this authorization.		
SECTIONS 1-7 MUST BE COMPLETED TO BE VALID			
Signature _____ Date: ___ / ___ / ___ Tel: (____)____ - _____			
If not patient: ☐ Patient's Representative Print Name and State Relationship: _____			

RECEIVED BY:

PLEASE WRITE CLEARLY OR WE WILL NOT BE ABLE TO PROCESS THIS REQUEST.

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