Santa Barbara Neighborhood Clinics
Quality Affordable Healthcare

Patient Demographic Form

Date: _____

Patient Information

Patient Name: _____ **Date of Birth:** _____ **SS/ITIN#:** _____

Birth Sex:
❑Female
❑Male

Gender Identity:
❑Choose not to disclose
❑Female
❑Genderqueer/Nonbinary/Other
❑Male
❑Transgender Woman/Transgender Female/Transfeminine
❑Transgender Man/Transgender Male/Transmasculine

Sexual Orientation:
❑Bisexual
❑Choose not to disclose
❑Don't Know
❑Lesbian, gay, or homosexual
❑Something else
❑Straight or Heterosexual

Preferred Pronoun:
❑Asked but unknown
❑Decline to Answer
❑He, Him, His
❑Other
❑She, Her, Hers
❑They, Them, Theirs
❑Ze, Hir

Address:
_____
Street Address, City, State, Zip Code
_____

Mobile Phone:_____
Alternate Phone:_____
E-mail:_____

Text and Voice Reminders:
❑ Opt out
❑ SMS (Text)
❑ Voice Reminders

How may we contact you?

Alt. Phone	❑Yes	❑No
Cell Phone	❑Yes	❑No
Email	❑Yes	❑No
Home Phone	❑Yes	❑No
Patient Portal	❑Yes	❑No
U.S. Mail	❑Yes	❑No

Primary Language:
❑English
❑Spanish
❑Other:
_____

Marital Status:
❑Divorced
❑Domestic Partner
❑Married
❑Single
❑Widowed

Work Status:
❑Full-time
❑Not Applicable
❑Not Employed
❑Part-time
❑Refused
❑Retired
❑Self Employed
❑Student
❑Unknown

Work Type:
❑Housekeeping, hotel and food services
❑Arts, entertainment, and recreation
❑Construction
❑Educational services
❑Federal, state, and local government
❑Finance and insurance
❑Healthcare and social assistance
❑Information Technology
❑Professional, scientific, and technical services
❑Real estate and rental and leasing
❑Retail trade and selling of goods
❑Transportation & warehousing
❑Utility Services
❑Manufacturing
❑Other
❑Not Applicable

What is the patient's highest level of education completed?
❑Less than high school
❑High school diploma or equivalent
❑Trade School
❑Some college, no degree
❑Associate's degree
❑Bachelor's degree
❑Master's degree
❑Doctoral or professional degree
❑Unreported/Refuse To Report

UDS

Present Living Situation:
❑Doubling up
❑Living with relatives
❑Not Homeless
❑Other
❑Own a Home
❑Rent home, or room
❑Shelter
❑Street
❑Transitional
❑Unknown/Unreported

Are you an Agricultural, Cattle, or Poultry Farm Worker?
❑Farmworker
❑Not a Farmworker
❑Seasonal

Are you a veteran?
❑Yes ❑No

Race: (Select one or more):
❑American Indian/ Alaskan Native
❑Asian
❑Black/African American
❑More than one race/Other
❑Native Hawaiian
❑Other Pacific Islander
❑Unreported/Refused To Report Race
❑White

Ethnicity (select one):
❑Hispanic/Latino
❑Not Hispanic/Latino
❑Unreported/Refuse To Report

Are you comfortable communicating in English?
❑Yes ❑No

Guarantor/Responsible Party

Is this patient the Responsible Party (over 18 years of age and/or legally responsible for self)? ❑Yes ❑No
If yes, skip to Household Income and Family Size

Responsible party name:_____ D.O.B._____

❑Parent ❑Legal Guardian ❑Healthcare Proxy ❑Other:_____ SS/ITIN#:_____

Address (if the same as patient, write "same"): _____

_____

Phone (Select preferred method): ❑Home ❑Alternate ❑Mobile

Monthly Household Income $ _____ **Family Size:** _____

Emergency Contact

Emergency Contact Name: _____ **Phone number:** _____

Relationship to Patient: _____

May we discuss your medical information with this person? ❑*Yes* ❑*No*

Marketing

How did you learn about this clinic?

❑Newspaper Advertising	❑Internet/Website	❑Friend/Relative/SBNC Employee
❑School	❑Cottage Health/Hospital	❑Flyer/Brochure/Door Hanger
❑Television	❑News Article	❑County Clinic/Behavioral Wellness
❑Radio	❑Health Fair/Presentation	❑Other Healthcare Provider
❑CenCal/Insurance	❑Community Organization	❑Facebook/Social Media

Insurance(s) & Non –Provider Patient Agreement

Primary Insurance Name: _____ **ID #:** _____

Name of Insured ,if not patient: _____

Secondary Insurance Name: _____ **ID #:** _____

Name of Insured, if not patient: _____

If I have been informed by a staff member that SBNC is not a participating provider of my insurance plan, SBNC has agreed to bill my insurance company as a courtesy. I understand that I am responsible for my co-payment and any unpaid portion that is not paid to SBNC by my insurance company. I will notify SBNC anytime my insurance plan changes.

Signature of Patient or Responsible Party _____ **Date:** _____

No Shows/Cancellations

After three missed appointments (not cancelled within 24 hours) in a twelve month period, you will be asked to find another healthcare provider. You will be seen for urgent care and medication refills for a 30-day period after which you will no longer be considered under the care of the Santa Barbara Neighborhood Clinics.

Three attempts shall be made to contact you. Upon the third failed attempt, a letter (Certified/Return Receipt) will be mailed to your address. A copy of the letter and receipts will be scanned into your electronic health record.

Signature of Patient or Responsible Party _____ **Date:** _____

Advanced Healthcare Directives

An Advance Health Care Directive is a way to instruct doctors, nurses and other healthcare providers about your wishes if you are unable to speak for yourself. It is a legal document that states who you wish to make decisions for you if you are unable to make them yourself due to illness or injury. It also allows you to give other instructions, like setting limits on the treatment you wish to receive if you are terminally ill or injured or donation of organs.

You do not need a lawyer to complete an Advance Health Care Directive. We can provide you with a blank form that you can complete on your own. It must be signed before a notary public or witnessed by two adults who also sign the form.

We will place a copy of your signed Advance Health Care Directive in your medical record. You should keep the original copy and it is important that your family and close friends know about the existence of the Directive and where the original is kept.

- ❑ I do not desire additional information about the Advance Health Care Directive
- ❑ I have already executed an Advance Health Care Directive
- ❑ I would like more information about the Advance Health Care Directive

HIE Consent

SBNC is a member of Cottage Community Health Information Exchange (CC, HIE), a secure data portal for the purposes of accessing vital health information between medical providers and the hospital for your treatment and billing. This is a disclosure that your health records may be shared, confidentially with authorized other health care providers and their business associates as members of the exchange and shall not be used or disclosed for any purposes prohibited by applicable health information privacy protection laws.

❑No, do not share my information with the HIE/CeHC

Signature of Patient or Responsible Party _____ **Date:** _____

Acknowledgements: I have executed a copy of the SBNC Consent for Treatment and Evaluation & Acknowledgement of Receipt of Notice of Privacy Practices and I consent to the matters contained therein. By signing below I acknowledge that I have read the information on Insurances &Non-Provider Patient Agreement, No Show/Cancellation Policy, Advanced Healthcare Directives, and HIE Consent.

Signature of Patient or Responsible Party: _____ **Date:** _____

Santa Barbara Neighborhood Clinics
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CONFIDENTIAL PEDIATRIC MEDICAL HISTORY

Your answers will help us to provide your child with the best medical care. Some of the questions may not apply to them or seem important. Nevertheless, please answer as accurately and completely as you can. This will become a permanent part of your child's confidential medical record.

Name: _____ Date of Birth: _____Today's Date: _____

- List any medications your child has allergies to: _____
- What medication is you child taking regularly? _____
- What medical conditions does your child have? _____
- Past hospitalizations/serious illness: _____
- Please list any surgeries/operations: _____
- Does your child wear glasses or contacts? ❑ Yes ❑ No
  - ❖ *If you have your child's vaccination card, please give it to the receptionist to copy*

EARLY CHILDHOOD

Is this child: Adopted? _____ In Foster Care or Guardianship? _____

Did the mother have any serious illness, high fevers, rashes, toxic exposures, accidents or smoke cigarettes or drink alcohol?

Yes _____ No _____

Delivery: Did the mother have any problems? Yes _____ No _____

Newborn: Did the baby have any problems Yes_____ No _____

Birth Weight _____ (pounds or kilograms)

Place of Birth: City _____ Hospital _____

Onset Age: Sat _____ Crawled _____ Walked _____ Talked _____

CHILD AND FAMILY HISTORY: PLEASE CHECK THOSE THAT APPLY TO THE CHILD OR FAMILY MEMBER

Child	Family		Child	Family	
_____	_____	High Blood Pressure	_____	_____	Anemia
_____	_____	Heart Disease	_____	_____	Asthma
_____	_____	Cancer, Type _____	_____	_____	Allergies/Hay Fever
_____	_____	Ear Infections	_____	_____	Bronchitis
_____	_____	Migraine Headaches	_____	_____	Diabetes
_____	_____	Skin Problems	_____	_____	Kidney Disease
_____	_____	Liver Problems	_____	_____	Epilepsy
_____	_____	Digestive/Bowel Problems	_____	_____	Vision Problems
_____	_____	Genetic/Familial Condition	_____	_____	Thyroid Problems
_____	_____	Developmental Problems	_____	_____	Attention Difficulties
_____	_____	Behavioral Problems	_____	_____	Discipline Problems

Does your child have a disability?

❑ Blindness, visual impairment
❑ Deafness, hearing impairment
❑ Mobility impairment

Does the parent or child have difficulty completing health forms?

_____

Comments:

Provider Signature:_____ **Date**_____

Signature of Patient or Responsible Party_____

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MRN:_____

Name: _____

Consent for Evaluation and Treatment

Santa Barbara Neighborhood Clinics (SBNC) is dedicated to providing primary medical, dental, behavioral health, and substance use disorder services. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. SBNC patients may be referred to providers from other health care specialties within the SBNC treatment team; members of the treatment team will share clinical information with each other as is clinically necessary.

Patients will be seen by appointment only, except in emergencies. All SBNC Clinics maintain same day appointments for urgencies. Patients are requested to cancel at least 24 hours in advance if the patient cannot keep their appointment.

Information about the patient will NOT be given to anyone outside SBNC, including family and friends, unless the patient (parent or legal guardian, of a minor) gives written permission. Patient may consent to release of his/her information if Patient is age 12 or older for behavioral health and family planning care, 18 or older for primary or dental care. However, we may release Patient's information to others without the Patient's permission if: 1) Patient poses a threat to him/herself or others; 2) Patient is unable to protect him/herself from risk of harm; 3) Patient is in the legal custody of a government agency or facility; 4) There is evidence of child abuse; or 5) Patient's clinical records are requested under court order including a subpoena to which Patient does not object promptly. Please refer to SBNC's HIPAA Privacy Policy.

There are fees for all services, and Patient is required to pay on the day of service. Health insurance policies may cover all or a portion of the fees and staff will help Patient in understanding their financial responsibility. Patient shall tell SBNC staff about changes in financial status including insurance.

The professional staff of SBNC will depend on statements made by Patient, Patient's medical history, and other information to evaluate their condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

Health professions are not exact sciences and no guarantees are made concerning the course or effect of treatment proposed by the provider, nor outcomes of treatment. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the treatment staff.

In treating patients, studies including imaging, (x-rays, photographs, and scans), laboratory tests, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff. Patient accepts the risks of medication and other treatment.

I understand, that if I am 12 years of age or older, I may consent for Mental Health, substance use disorder and/or Reproductive Health services; otherwise my parent or legal guardian will need to consent for services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or my child(ren) as set forth above, including any studies or procedures that SBNC professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

_____ _____

Patient's and/or Guardian's Signature Date

_____

Print Name

_____ _____

Witness Date

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SBNC Consent for Evaluation and Treatment of a Minor

I _____, as parent or legal guardian
Name of Parent or Legal Guardian

of _____, a minor, authorize medical
Name of Patient

treatment and evaluation as deemed necessary by the medical staff of the Santa Barbara Neighborhood Clinics.

I acknowledge and understand that I am responsible for all the charges of the services rendered to this patient.

_____ _____
Signature of Parent or Guardian Date

_____
Relationship to Patient

Santa Barbara Neighborhood Clinics
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SLIDING FEE SCALE ELIGIBILITY DETERMINATION APPLICATION
DO NOT complete form if your visit is covered under CenCal or Medi-Cal

Patient Name:_____Date of Birth:_____

Income: $_____Select one: ❑ Weekly ❑ Monthly ❑ Yearly

Family Size: _____*(Self, spouse and children under 18 years of age)*

Financial Verification Source and Attach Copy *(Select One):*
❑ Tax Return
❑ Unemployment
❑ Supplemental Security Income (SSI)
❑ Check Stubs
❑ Social Security Disability Insurance (SSDI)
❑ Other:_____

I certify that under penalty of perjury that I am NOT eligible or currently covered by CenCal or Medi-Cal Initial:_____

I understand payment is due and collected at the time of service. Initial:_____

I understand medications may be at an additional charge. Initial:_____

I understand laboratory services may be at an additional charge. Initial:_____

I understand procedures may be at an additional charge. Initial:_____

I understand specialty appointments may be at an additional charge. Initial:_____

Patient/Parent/Guardian Signature:_____Date:_____

Revised: 3/27/2017

Santa Barbara Neighborhood Clinics
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SBNC Patient Rights and Responsibilities

As an SBNC patient, you have the right to:

1. Courteous and considerate treatment and to be treated with dignity and respect by all SBNC clinicians and staff.
2. Have the privacy and confidentiality regarding your medical records to be protected.
3. Receive reasonable information regarding the qualifications of the provider of care, risks of a given treatment, and the length of disability — prior to giving consent for any procedure.
4. A reasonable response to a request for services, including evaluations and referrals.
5. Be fully informed of the Santa Barbara Neighborhood Clinics' grievance procedure and how to use it without fear of prejudice treatment from your health care provider.
6. Voice complaints and receive a timely response.
7. Receive a second opinion when such an opinion is deemed medically appropriate by the assigned.
8. Receive, upon request, the names, specialties, and titles of the professionals responsible for their care.

As an SBNC patient, you are responsible to:

1. Cooperate with those providing health care services. However, you have the right to refuse medical treatment.
2. Treat all clinic staff and providers with courtesy and respect.
3. Contact your clinic regarding any questions or concerns about your health or services, or when seeking care (except in an emergency).
4. Provide the professional staff with all the information they need to give you the best care possible.
5. Follow instructions and guidelines given by those providing health care services.
6. Keep all appointments and arrive on time. If you are unable to keep an appointment, it is to be canceled 24 hours in advance.
7. Follow the recommendations for preventive care, yearly check-ups, and a healthy lifestyle.
8. Not consume alcohol or substances while on the premises.
9. Not come to the clinic while under the influence of alcohol or drugs as this may impair your ability to fully engage in your treatment.

Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____