Ritter Center Health Center

New Patient Registration Form

TODAY'S DATE: _____

Last Name	**First Name**	**MI**	**Date of Birth**
Street Address:			
City:	**State:**	**ZIP CODE** *(required field)*	

Gender: ☐ Male ☐ Female ☐Transgender Male (Female to Male) ☐Transgender Female (Male to Female) ☐Other ☐Choose Not to disclose	**Sexual Orientation:** ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose
Email:	**Phone number: ( ) -** Okay to leave a message at this number? ☐ Yes ☐ No
Social Security Number: ____ -____-_____	**Veteran:** ☐Yes ☐No **Are you disabled?** ☐Yes ☐ No
Marital Status: ☐ Single ☐Married ☐Living with partner ☐Widower	**Preferred Communication**:☐ Verbal ☐ Written ☐Sign Language **Primary Language:**
Hispanic/Latino: ☐Yes ☐ No	**Housing Status**: ☐ Own ☐ Rent ☐ Homeless
Race (check all that apply): ☐Caucasian/white ☐ American/Alaskan Native ☐Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black or African American ☐ Decline to Say	**If Homeless:** ☐ Homeless Shelter ☐ Transitional Housing ☐ Staying temporarily with Friends/Relatives ☐ Public Housing ☐ Other ☐ Street or Car
Employment Status: ☐Yes ☐ No ☐Retired **Migratory/Seasonal Agricultural Workers** ☐Yes ☐ No ☐Retired	☐**Student:** ☐Yes ☐ No

Emergency Contact Name	**Relationship to Patient**	**Phone Number**

Patient Insurance

Insurance: ☐ **None** ☐ **Medi-cal** ☐ **Medicare** ☐ **Other**	
Primary Insurance:	**Subscriber ID:**
Do you want Ritter Health Center to be your Primary Care Doctor? ☐ **yes** ☐ **no**	

Sign & Authorize

The information I gave on this form is true and correct to the best of my knowledge.

- I give consent for the employees at Ritter Center Health Center (RCHC) to do the medical exams, procedures, treatment, and referrals they need to care for me.
- I agree to follow RCHC payment rules for the services I get.
- I authorize the release of any information RCHC needs to process my medical claims.
- I authorize the payment of any government benefits or insurance payments due to RCHC for services they give me.

☐ For Ritter Health Center clients: I understand that my medical and mental health records may be shared internally with Ritter Center staff and externally with other health care providers who are involved in my care, to coordinate treatment and services and help facilitate referrals.

☐ For Ritter Safety Net clients: I understand that my substance use treatment records will only be shared with others outside of the Ritter Center Safety Net program if I have provided authorization for such disclosure.

I give RCHC permission to review pharmacy records related to the health care I get: **_____** (initial here)

_____

(Patient Signature)

Sliding Scale Fee Application and Income Declaration Form

Ritter Health Center provides services regardless of your ability to pay. Based upon your income, a discount may be available. Ritter Center will use the information you give on this form only to see if you qualify under the Sliding Scale Program of the Federal Poverty Income Guideline. The Sliding Scale lets you pay a reduced price for some services at Ritter Center. Please include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment, and public aid.

1.) Name (Please Print):_____

2.) What is your monthly income, before taxes are taken out? $_____

3.) What is you household's combined income? $_____

4.) Where does this income come from? (Work, disability, etc.) _____

5.) How many family members live with you? (count only your spouse & children) _____

I certify that the information I gave on this form is true and accurate to the best of my knowledge.

_____ _____

Patient Signature **Date**

MARIN COUNTY HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

Client Consent for Data Collection and Release of Information

WHAT IS THE HMIS?

The HMIS is a data system that stores information about homelessness and housing services and programs. The purpose of the HMIS is for homeless provider agencies to record information about clients that they serve. This information helps the provider agencies plan for and provide services to clients and to meet requirements of funders such as the U.S. Department of Housing and Urban Development (HUD). HMIS also allows agencies to improve services that support people who are homeless by allowing authorized staff to share client information with the permission of the client. Marin County Health & Human Services manage the HMIS for Marin County.

WHAT IS THE PURPOSE OF THIS FORM?

With this form, you can give permission to have information about you collected and shared with the different Partner Agencies that provide housing and services in Marin County. A current list of Partner Agencies is at http://marin.clarityhs.help. At this time, the Partner Agencies include:

Adopt A Family of Marin
Buckelew
Downtown Streets Team
Homeward Bound of Marin
Homeless Outreach Team (HOT)
Marin Community Clinics
Marin County Health & Human Services
Marin Housing Authority
St. Vincent de Paul Society
Ritter Center
U.S. Department of Veterans Affairs (VA)

BY SIGNING THIS FORM, I AUTHORIZE Marin County and Partner Agencies to share my information entered into the HMIS. The HMIS information shared will be used to help provide housing and services, which includes care coordination, counseling, food, utility assistance, and to evaluate and improve the quality of housing and service programs. I understand that the Partner Agencies may change over time and that I may find a current list at http://marin.clarityhs.help.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- The information to be collected and shared includes:
    - Name, birthday, gender, race, ethnicity, social security number, contact information, veteran status
    - Basic information on self-reported disabling conditions caused by medical, mental health, substance use or developmental factors, including self-reported HIV/AIDS status.
    - Housing Information
    - Employment, income, insurance and benefits information
    - Services provided by Partner Agencies
    - My answers to assessment questions, including the VI-SPDAT questionnaire
    - My photograph or other likeness (if included)
- I may refuse to provide any of this information. If I refuse, I will not lose any benefits or services.
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- Marin County and Partner Agencies will keep my HMIS information private using strict privacy policies. I have the right to review the privacy policies that govern this information.

- Marin County Health & Human Services and BitFocus use passwords and encryption technology to ensure that information in the system is safe, and each HMIS User and Partner Agency has signed an

agreement to maintain the security and confidentiality of HMIS data. However, there is always a small risk of a security breach, and someone might obtain my information and use it inappropriately. Marin County and Partner Agencies are required to alert me if they know of a breach.

- If I have questions about my HMIS information, my rights regarding that HMIS information, or am concerned that my information has been misused, I can contact my HMIS systems administrator at marin@bitfocus.com.
- I can receive a copy of this Consent and the Client Information Sheet.
- This Consent will expire 3 years from my last HMIS recorded activity.
- I may revoke this Consent at any time by sending a written request to marin@bitfocus.com or by contacting the Partner Agency that is providing this Release of Information.
- My HMIS information may be shared to coordinate referral and placement for housing and services.
- My HMIS information may be further shared by the Partner Agencies to other agencies if needed for care coordination, counseling, food, utility assistance, and other services.
- My HMIS information may be included in reports for auditors or funders who review the work of the Partner Agencies, including HUD, the Department of Veteran Affairs, the Marin County Department of Health and Human Services, and the California Department of Housing and Community Development. I understand that the list of auditors and funders may change over time. My identity will not be shared in these reports.
- My HMIS information may be used for research; however, my identity will remain private.

____ I have been offered and declined a copy of this form **OR**

____ I have received a copy of this form

SIGNATURE: Date:

_____ _____

Printed Name:

_____

FOR AGENCY USE ONLY:

Client Opted Out/Refused Consent: _____ (Staff/Agency Initials)

_____ _____

Witness Staff & Agency Date

RITTER HEALTH CENTER
Notice of Privacy Practices – Health Care Clients

We care about protecting your private information and supporting your rights. This is our new Notice of Privacy Practices which goes into effect on September 11, 2020. We hope you find it helpful and easy to understand. Please read it carefully. If you have any questions, you can contact our Privacy Officer via email privacy@rittercenter.org and we'll be happy to speak with you!

Your Rights
When it comes to your health information, you have certain rights.

Ritter Center is committed to maintaining and protecting the confidentiality of your private health information. When we use the term health we will always mean both your physical and mental health. Ritter Center is required by federal law, including the Health Insurance Portability and Accountability Act (HIPAA) to provide you with this Privacy Notice, which describes our policies, safeguards, and practices. Whenever Ritter Center uses or discloses your protected health information, we are bound by the terms of this Privacy Notice.

This section explains your rights and some of our responsibilities to help you.
You have a right to:

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Your request must be in writing. Ask us for a form.
- You can ask your staff or our Privacy Officer for any of the forms in this notice. The contact information is on the last page of this notice.
- We will provide a copy of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health information about you that you think is incorrect or incomplete.
- Your request has to be in writing. We'll give you the form and help if you need it.
- If we say "yes" and agree with your request, we will amend the information in your record.
- We may say "no" to your request, but if so, we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way. For example, you may have a different number you want us to use to leave a message, or a different address to send mail.
- We will say "yes" to all reasonable requests. If we are unable to, we'll tell you why.

Ask us to limit what we use or share
- We may use your information with other qualified professionals for treatment, payment, or our operations. You can ask us not to share certain health information for these purposes.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you directly asked us to make).

- We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Your Right to File a Complaint

- If you feel your privacy rights have been violated and wish to file a complaint, or have any questions or concerns about our privacy practices, please contact our Privacy Officer: privacy@rittercenter.org or call toll-free 888-368-4111
- You will not be penalized for filing a complaint
- You may also file a complaint directly with the USDH Office of Civil Rights U.S. Department of Health & Human Services Office for Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 877-696-6775 OCRMail@hhs.gov www.hhs.gov

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Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information for in the following ways:

Treatment
- For the coordination of your treatment with other health care providers who are treating you.
- This includes other health and behavioral health care staff both within and outside of Ritter Center. Example: a discussion between your primary doctor and a mental health therapist or case manager about your treatment plan.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. Example: to bill Medi-Cal or Medicare for the cost of your health care.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Ritter Center participates in system-wide health care initiatives

- **The Marin Health Gateway Health Information Exchange (HIE).** We participate in a data-sharing and integration service through a secure and confidential HIE electronic system. The HIE enables the appropriate and secure exchange of health information among HHS staff, community clinics in Marin County, Marin General Hospital, Detention Health Services, the Medi-Cal Managed Health Plan and other external partners - assisting healthcare providers and health care officials to make informed decisions, improving coordination and quality of care.
- **You have a right to obtain a list of participating providers upon request.** You have a right to opt out of the HIE. Just ask us how and we'll help.
- **Redwood Community Health Center Coalition (RCHC).** We participate in an "organized health arrangement" with RCHC. Through this health arrangement Ritter Center participates in utilization reviews, quality assessments and improvement activities, and payment activities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

Help to prevent harm to yourself or others

We can disclose your information to reasonably lessen the risk of harm if we believe you present a serious and imminent threat to your own health or safety, or there's a danger to someone else, or to the public.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

Do research

- We can use or share your information to qualified personnel for health research (for example, comparing treatment outcomes of patients who received one type of treatment to those who received another) or for an audit or program evaluation.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Our Privacy Officer

You can get more information about your rights, obtain forms, and get assistance with any of your privacy rights or questions by contacting our Privacy Officer: privacy@rittercenter.org or call toll-free: 888-368-4111

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. If Ritter Center makes significant changes, you will be informed of the new Notice and offered a copy on your next visit for treatment. The new Notice will be posted on the Ritter Center website.

The privacy practices listed in this Notice are effective September 11, 2020.

Acknowledgement of Receipt of the Ritter Center Notice of Privacy Practices by Health Care Patients

I acknowledge that I have received and reviewed the Ritter Center Notice of Privacy Practices

Name/DOB: _____/_____ Date: _____

Ritter Center Health Center

Advance Directive

TODAY'S DATE: _____

Last Name:	**First Name:**	**MI:**	**Date of Birth:**

Do you have an advance directive or power of attorney for healthcare?

YES _____ NO_____

Would you like more information?

YES_____ NO_____

Information given

_____ _____

Patient Signature **Date**

ritter center

SWORN STATEMENT

_____ _____

Medical Record Number *Patient Name*

I, (print name) _____ , present the following information as my Sworn Statement of facts. I am presenting this sworn statement because other verifications of this fact/these facts cannot be obtained at this time.

I swear or declare, under penalty of perjury, that:

- ☐ I have no money to pay my/my dependent's co-pay and deductible
- ☐ I have no money to pay for my/my dependent's share of costs
- ☐ I have no money to pay for my/my dependent's prescription(s)
- ☐ I have no money to pay for my/my dependent's lab work
- ☐ Other: _____

Because: _____

_____

Any person who signs this statement and willfully states as true any material matter which he/she knows to be false is subject to the penalties prescribed for perjury in the Penal Code by the State of California (see 11054 of the Welfare and Instructions Code).

I solemnly declare under penalty of perjury that the statements made herein are true and correct to the best of my knowledge and belief. I am aware that it is unlawful to give false information.

_____ _____

Printed Name of Patient *Signature of Patient or Guardian*

Date: _____

Witnessed by:

_____ _____

Printed Name of Witness *Signature of Witness*

Date: _____

ritter center

Primary Care Provider (PCP) Selection Form
SOUTHERN REGION:
Lake, Marin, Mendocino, Napa, Solano, Sonoma and Yolo Counties

Please fill out this form for yourself and each member of your family who has Medi-Cal. Use PHC's list of Primary Care Providers (PCPs) to pick your PCP.

Last Name	First Name	Date of Birth			Medi-Cal ID # or Social Security No.
		MO	Day	Yr	
Name of Doctor or Medical Group		Provider # of Doctor or Medical Group			Provider's Phone Number
Ritter Health Center		17353-0004			415-4578182x111

Last Name	First Name	Date of Birth			Medi-Cal ID # or Social Security No.
		MO	Day	Yr	
Name of Doctor or Medical Group		Provider # of Doctor or Medical Group			Provider's Phone Number

Last Name	First Name	Date of Birth			Medi-Cal ID # or Social Security No.
		MO	Day	Yr	
Name of Doctor or Medical Group		Provider # of Doctor or Medical Group			Provider's Phone Number

1. Provide the following information for anyone listed on this form who is pregnant:
   Name: _____ Due Date: _____

2. I understand that I have a choice of Primary Care Providers (PCPs) that are contracted with Partnership HealthPlan of California (PHC).
3. I understand that if I do not choose a PCP, PHC will assign one to me.
4. I understand that I can change my PCP and that the change will be effective the first of the month after the change was requested.

To ensure that we have the most current information, please provide current mailing address:

ritter center

Address: _____ City: _____

Zip Code: _____ Phone Number: _____

E-mail Address:

_____

How would you like to receive your PHC Member Newsletter? □ E-Mail □ Regular Mail

PHC is required to report your address and phone number changes to your county's Medi-Cal office. This excludes members receiving SSI benefits.

Signature: _____ Date: _____

Return to: Partnership HealthPlan of California, 3688 Avtech Parkway, Redding, CA 96002 or you can fax to (530) 223-2508.

Click here to email this PDF to Clinic Manager Rachelle Valenzuela