




PUREVIEW | Health Center

Legal Name	Last	First	Middle Initial	Preferred Name
Legal Sex (please check one) <input type="radio"/> Female <input type="radio"/> Male <i>*While PureView recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.</i>				Medical Provider: Name: _____ Phone: _____
Date of Birth	Month / Day / Year	Social Security #		Are You a Veteran? Yes No

Your answers to the following questions will help us reach you quickly and discreetly with important information

Home Phone () Okay to leave voice mail? Yes No	Cell Phone () Okay to leave voice mail? Yes No	Work Phone () Okay to leave voice mail? Yes No	Best number to use: <input type="radio"/> Home <input type="radio"/> Cell <input type="radio"/> Work
Address	City	State	Zip
Billing Address (if different from above)	City	State	Zip
Are You Homeless? Yes No (circle one) Shelter Transitional RV/Tent Doubling-Up Street Other _____			
Do you want to sign up for the patient portal? <input type="radio"/> Yes <input type="radio"/> No		Email Address: <input type="radio"/> None <input type="radio"/> Choose not to share	
Occupation/Employer:		Are you covered under your employer's insurance? <input type="radio"/> Yes <input type="radio"/> No	
Emergency Contact Name:		Phone #	Relationship to You
<i>If you are under the age of 18 we require that you provide parent/guardian contact information</i>			
Parent/Guardian Name		Phone #	Relationship to You
<i>PureView Health Center will send certain correspondence such as results from labs and Diagnostic Imaging to your mailing address, How would you like to receive this correspondence?</i> <input type="radio"/> Secure Email <input type="radio"/> Letter <input type="radio"/> Other			

PureView Health Center is federally funded. To be compliant with federal regulations, we are **required** to collect the following information from our patients. This will not impact the care you receive. Also, the personal information you provided prior to this section is for PureView Health Center use only and will not be shared elsewhere.

What is your Annual Income? \$ _____ <input type="radio"/> No income How many people, including you, does this income support? _____	Employment Status: <input type="radio"/> Employed Full Time <input type="radio"/> Employed Part Time <input type="radio"/> Student Full Time <input type="radio"/> Student Part Time <input type="radio"/> Retired <input type="radio"/> Unemployed <input type="radio"/> Disabled <input type="radio"/> Other _____	Racial Group(s) (check all that apply) <input type="radio"/> Asian <input type="radio"/> Native Hawaiian <input type="radio"/> Other Pacific Islander <input type="radio"/> Black/African American <input type="radio"/> American Indian/Alaskan Native <input type="radio"/> White <input type="radio"/> Refuse to report	Ethnicity: <input type="radio"/> Hispanic/Latino/Latina <input type="radio"/> Not Hispanic/Latino/Latina <input type="radio"/> Refuse to report Country of Birth: <input type="radio"/> USA <input type="radio"/> Other _____
Preferred Language: <input type="radio"/> English <input type="radio"/> Español <input type="radio"/> Français <input type="radio"/> Português <input type="radio"/> Other _____	Marital Status: <input type="radio"/> Married <input type="radio"/> Partnered <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Legally Separated	Referral Source: <input type="radio"/> Self <input type="radio"/> Friend/Family <input type="radio"/> Advertisement <input type="radio"/> Other _____	Please Turn Over 

PureView Health Center-Consent for Treatment

Date: _____

Printed Name: _____

I hereby give my consent and authorize PureView Health Center to treat any medical or mental health condition providing that the care provider has explained my condition.

I authorize the care provider to perform any additional or different treatment, which is thought necessary, should a condition be discovered during treatment that was not known previously.

I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all following medical or mental health visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that PureView Health Center may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I authorize my insurance benefits be paid directly to PureView Health Center, I also authorize PureView or Insurance company to release any information required to process my claims.

I certify that the above information is true and correct. I have received a copy of PureView's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

General Information: Informed consent will be obtained from all patients accessing medical, mental health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patients' condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

Missed Appointment Policy Statement

- PureView Health Center has adopted a No-Show (missed appointment) policy in March of 2016. This means any appointment that a patient does not attend and did not call the office to cancel or reschedule within an appropriate amount of time has no-showed an appointment,
- Please be advised that we require at least 24 hours of notice for any appointments that a patient is not able to keep. If a patient missed two appointments within 12 months by not calling to let our office know that they are not able to attend the appointment, we will not schedule an appointment for the patient for three months.
- **By signing below, the patient is stating that they have read and understand the No-Show policy statement, Consent to Treatment and Payment and Data Agreement as above.**

Date _____

Signature _____



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Date of Birth	Month	Day	Year	
	/	/		

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Do you think of yourself as: <input type="radio"/> Lesbian or Gay <input type="radio"/> Straight (not lesbian or gay) <input type="radio"/> Bisexual <input type="radio"/> Something else <input type="radio"/> Don't know <input type="radio"/> Choose not to disclose	What was your sex at Birth?: <input type="radio"/> Female <input type="radio"/> Male	Gender Identity: <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Transgender Male/ Female-to-Male <input type="radio"/> Transgender Female/ Male-to-Female <input type="radio"/> Other <input type="radio"/> Choose not to disclose
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Date _____

Signature _____

Please give to your nurse or provider when complete.