LA MAESTRA COMMUNITY HEALTH CENTERS
City Heights · El Cajon · National City · Lemon Grove

☐ La Maestra City Heights ☐ La Maestra National City ☐ La Maestra El Cajon 1032 Broadway ☐ La Maestra El Cajon ☐ La Maestra HOPE Clinic ☐ La Maestra Hoover High School ☐ La Maestra Rosa Parks ☐ La Maestra Monroe Clark ☐ La Maestra Central Elementary

PATIENT I.D. CARD

PATIENT NAME_____

MR#_____ DOB_____ M ☐ F ☐

PRIMARY PROVIDER_____ DATE_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: Last_____ First _____ MI___ Other Name(s) used _____

Social Security Number _____-____-_____ Date of Birth_____/_____/_____ ☐ Male ☐ Female

Mailing Address:_____City:_____State:_____Zip:_____

What is the patient's primary language?_____

May we contact you by phone? ☐ Yes ☐ No If yes, may we leave a ☐ brief or ☐ extend message on your phone?

May we contact you by text message? ☐ Yes ☐ No If yes, data rates may apply. La Maestra is not responsible for data charges.

Please check here if you understand and agree that you are responsible for text and phone charges: ☐ Yes ☐ No

May we contact you by email ☐ Yes ☐ No Email address:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Student: ☐ Yes ☐ No If yes, ☐ Full-time ☐ Part-time

Phone (home)_____(work):_____Cell:_____

INSURANCE INFORMATION

Primary Insurance Company Name | Insured Member Name | DOB | Insurance ID#

Medi-Cal ID# | Medicare ID#

Secondary Insurance Company Name | Insured Member Name | Insurance ID # | Insured Employer

If Uninsured or underinsured, are you interested in eligibility assistance for health coverage? ☐ Yes ☐ No

Employed: ☐ Yes ☐ No If yes, ☐ Full-time ☐ Part-time

Employer: _____ Address:_____

Preferred Pharmacy:_____Address:_____ Phone Number:_____

RESPONSIBLE PARTY (if patient is a minor complete this section)

Name: Last _____ First_____MI:_____

Relationships to patient:_____Phone (home):_____ (work):_____

Address (if different):_____ City:_____State_____Zip:_____

Date of Birth_____/____/_____ Social Security Number:_____-____-_____ Employer:_____

EMERGENCY CONTACT

Name:_____Phone Number (home):_____

Relationship to patient:_____Phone Number (work):_____

ADDITIONAL PATIENT INFORMATION (please answer all questions)

La Maestra is a nonprofit organization committed to serving the needs of our community. By answering the following questions, you will provide us with information we need to acquire grant funds to help uninsured and underserved individuals in our community. This information also helps us recognize clients who may qualify for specialty funded programs or services. Please help us by providing this information. This information will become part of your confidential medical record.

a) Has patient been homeless at any time since January of this year? ☐ Yes ☐ No

If yes, ☐ Homeless shelter ☐ Doubling up ☐ On Street ☐ In car or vehicle ☐ Unknown

b) What type of work does the patient do? (Please check one): ☐ Homemaker ☐ Professional ☐ Clerical ☐ Sales ☐ Service ☐ Laborer ☐ Agriculture. If Agriculture: ☐ Employed year round ☐ Migrant ☐ Seasonal ☐ Unemployed ☐ Retired

c) Preferred spoken language? ☐ English ☐ Spanish ☐ Arabic ☐ Other (please specify)_____
d) Is a translator required? If yes, in which language? _____
e) Does the patient reside in public housing? ☐ No ☐ Yes Does the patient receive section 8 housing assistance? ☐ No ☐ Yes
f) Race (please check one): ☐ African American/Black ☐ American Indian/Native American ☐ Alaska Native ☐ Asian ☐Caucasian/White ☐Native Hawaiian ☐Other Pacific Islander ☐More than one Race ☐Other (please specify)_____
g) Ethnicity (please check one): ☐ Hispanic ☐ Non-Hispanic
h) Are you a Veteran? ☐ Yes ☐ No
i) Number of people in patient's household _____Monthly household gross income (approximate): $ _____
g) Yearly household gross income (approximate): $_____

PAYMENT INFORMATION

La Maestra is a nonprofit organization. We depend on your prompt payment for services so that we can continue to provide high quality, low-cost care for our patients. We require payment at the time of service unless arrangements have been made with our billing department prior to the visit. We will bill your primary insurance carrier, but we do require you to pay your co-payment and any deductible you have not met at the time of service. We will bill supplemental insurance for our Medicare patients. Any amounts due after your insurance pays its portion will be billed to you. Payment is due upon receipt of your statement. You will be required to present your insurance card at each visit._____(initials).

CONSENTS

In order to provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent. Please provide us your consent by initialing each section below and by providing your signature below.

Assignment of Benefits/Financial Agreement: I authorize payment for all medical benefits to La Maestra for professional services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of payment default, I agree to pay all costs of collection, and legal fees._____(initials).

Release of Information: I authorize the release of all information necessary to secure the payment of benefits related to my care. I further agree that a photo copy or signed digital in print of this agreement shall be as valid as the original._____(initials).

CONSENT OF TREATMENT

I hereby authorize and consent to procedures necessary for diagnosis and treatment of myself and my family while a patient at La Maestra._____(initials).

AUTHORIZATION TO REVIEW PHARMACY HISTORY

I hereby authorize La Maestra to view my prescription history from outside sources._____(initials).

Your signature below indicates you have read, understand and agree to the above consents and to the patient rights and responsibilities.

Signed:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

La Maestra is committed to protecting your personal health information in compliance with the law. The organization's Notice of Privacy Practices States the following:

- Our obligation under the law with respect to your personal health information.
- How we may use and disclose health information that we keep about you.
- Your rights as our patients relating to your personal health information
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

I hereby acknowledge that I have received/been offered a copy of La Maestra's Notice of Privacy Practices.

Signed:_____ Date:_____

Parent/Patient's Representative: _____ Date:_____

_____

Description of Legal Authority to Act on Behalf of the Patient

Thank you for choosing La Maestra, and for your help in assuring that quality care is available in all communities served.