BRIGHTER BEGINNINGS
Every Family Matters

**Brighter Beginnings Family Health Clinic**
2213 Buchanan Rd, Suite 103, Antioch, CA, 94509
**Phone**: 925-303-4780 **Fax**: 925-326-9930

**Brighter Beginnings Family Health Clinic**
2727 Macdonald Ave, Richmond, CA 94804
**Phone**: 510-213-6681 **Fax**: 925-326-9930

Dear Patient/Client,

Welcome to Brighter Beginnings! If you have any questions or need to reschedule or cancel your appointment, please call **925-303-4780** if you attend the Antioch clinic or **510-213-6681** if you attend the Richmond clinic. Someone will answer the phone if we are closed, including weeknights and weekends. Bring as many of the following documents with you to your appointment as you can.

1. **Valid ID**
2. **Health Insurance Card**
3. **Birth Certificate/ Passport/ Naturalization Card**
4. **Proof of residency**
5. **Income verification (last 2 pay stubs)**
6. **Social Security Card(s)**
7. **Most recent income tax return, W-2 Form, or 1099 Form**
8. **List of medication(s) or medicine bottles of medicines your are currently taking**
9. **Immunization records**
10. **Complete Brighter Beginnings Medical and Dental Clinic Patient Registration Form**

These documents are required to determine eligibility for Covered California, Emergency Medi-Cal, Medi-Cal, General Relief, or other financial assistance programs or services. We see all patients regardless of whether or not you can pay. If you fall under 200% of the federal poverty guideline, we could bill your insurance or you may qualify for our sliding fee schedule program depending on your co-payment amount. **Failure to provide these documents may limit our ability to provide comprehensive services through Brighter Beginnings.**

Thank you,

Your Brighter Beginnings Care Team

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**Proof of Citizenship or Lawful Presence** (you only need one of these per person)

- U.S. Passport
- A valid state-issued driver's license
- Birth Certificate
- Department of State Form DS-1350
- Certificate of Child Born Abroad
- Department of State Form FS-545
- Department of State Form FS-240
- Certificate of Birth Abroad
- Certificate of Naturalization
- Immigration and Naturalization Services (INS) Form N-550
- INS Forms N-570
- INS Forms N-578
- INS Forms N-565
- INDV Fee Register Receipt (INS Form G-711)
- Certificate of U.S. Citizenship
- INS Form N-560
- INS Form N-561

**Proof of Income** (you only need one of these per person)

- Pay stub or copy of pay stub
- Copy of pay stub showing garnishment specific for alimony
- Copy of last year's federal tax return that accurately reflects the current income
- Copy of last year's federal tax return along with federal schedule C, D, E, or F as appropriate that accurately reflects current income
- Signed letter from employer that displays the gross income, payment frequency, and date of paycheck
- Affidavit
- Form 1099
- Bank statement
- Investment account statement
- Payment records (notes and mortgages)
- Gift income letter
- Lease or sales agreement
- Other documents to support Proof of Interest Income
- Records such as gross rents and expense receipts
- Business records such as profit and loss statements
- Other documents to support Proof of Rental Income
- Receipts displaying gross profit and expenses
- Copy of last year's federal tax return along with federal schedule E that accurately reflects current income
- Copy of check
- Sworn affidavit from absent parent
- Current bank statement
- Other documents to support spousal income and child support
- Award letter or most recent cost of living increase notice
- Copy of the current benefit check
- Signed statement from the individual or organization

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# NEW PATIENT REGISTRATION FORM

**Please fill out completely and ask for help if you have questions.**

**Today's date:** _____

**Patient Name:** _____ **DOB:** _____

**Gender:** ❒ Male ❒Female

❒Transgender Male/Trans Man/Female-to-Male

❒Transgender Female/Trans Woman/Male-to-Female

❒Genderqueer, neither exclusively Male nor Female.

❒Other (please specify) _____

❒Decline to specify

**Sexual Orientation:** ❒Straight or heterosexual ❒Bisexual ❒Lesbian, gay, or Homosexual

❒Decline to specify ❒Other, please describe _____

**Address:** _____

Street City State zip

**Home Phone #: (  )** _____ **Cell phone#: (  )** _____

**Do you have a Social Security Number**: ❒yes ❒ No **or ITIN** ❒yes ❒ No

**Social Security OR ITIN #:** _____

**Is your Social Security # for employment only?** ❒yes ❒No

**Employment Status:** ❒ Employed Full Time ❒ Employed Part Time ❒ Not Employed

Name of Employer (if applicable) _____ Job _____

**Email Address:** _____

**(Note: If you have Email, your provider can communicate directly with you and you can see your test results online)**

**Name of preferred Pharmacy:** _____

**Street:** _____ **City**_____

**Living Situation**: ❒Own ❒Rent ❒Motel/Hotel ❒Car ❒Shelter

❒Staying with family/friends ❒Other

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**Marital Status**: ❒Single ❒Married ❒Separated ❒Divorced ❒Widowed ❒Domestic Partner

**Are you disabled:** ❒Yes ❒No

**Ethnicity/Race:** ❒American Indian or Alaska Native ❒Hispanic or Latino ❒Asian
❒Black or African American ❒Native Hawaiian or other Pacific Islander ❒White

**Education level completed:**
❒ Less than high school graduate
❒ High school graduate
❒ Some College/ associate degree
❒ Bachelor's degree

**What language should your information be in?** _____

**How well do you understand English?** ❒Very well ❒Moderate ❒Very little ❒None

**Name of emergency contact:** _____**Relationship:**_____
**Phone# (  )** _____

**If minor, Mother's name** _____ **If minor, Father's name** _____

**How did you hear about our clinic?** _____

1. **Do you have health insurance?** ❒Yes ❒No **If YES, what insurance company?**
   _____

2. **Do you have Medi-Cal:** ❒Yes ❒No
   **If YES, is it Emergency Medi-Cal?** ❒Yes ❒No

3. **Do you have Contra Costa Health Plan?** ❒Yes ❒No
   **If NO, have you applied?** ❒Yes ❒No

**I understand that my medical information is confidential. I authorize the exchange between this clinic and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. A copy of Patient Rights and confidentiality policies are available upon request.**

**The exchange of information may include treatment for:**
Alcohol/Drugs: ❒Yes ❒No **Initials** _____
Psychiatric Drugs: ❒Yes ❒No **Initials** _____
STD/AIDS ❒Yes ❒No **Initials** _____

**I HEREBY AUTHORIZE TREATMENT BY THE CLINIC:** ❒Yes ❒No **Initials:** _____

**Patient Signature or Guardian:** _____ **Date:**_____

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# AUTHORIZATION FOR TREATMENT

Medical care is a patient care service in response to a wide range of medical care needs of patients of all ages regardless of gender, color, race, creed, national origin or disability, five days a week.

The purpose of medical care is:

- To treat disease, injury and disability by examination, testing and use of procedures, in the aid of diagnosis or treatment.
- To obtain information needed in diagnosing and examining patients.
- To prevent or minimize residual physical and mental disability.
- To aid patients in achieving their maximum potential within their capabilities.
- To accelerate convalescence and reduce the length of the functional recovery.

All procedures will be thoroughly explained to you before you are asked to perform them. You are not expected to experience any increase in your current level of pain or discomfort. You should stop procedures before you experience any increase in your current level of pain or discomfort.

You are expected to cooperate fully with the examination and stop any test or procedure before experiencing any increase in your current level of pain discomfort. There are certain inherent risks with medical care. You will be able to stop any procedure if you feel any discomfort. The attending physician will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information, I agree to cooperate fully and to participate in all medical care procedures and comply with the plan of care as it is established.

I acknowledge that I have read and received copies of the authorization for Treatment and patient's rights and Responsibilities.

**Notice to Patients**

For your personal safety, do not use any equipment without a staff member present.

**Patient print name: _____ DOB: _____**

**Patient Signature: _____ Date: _____**
**(Signature of Parent or Legal guardian if patient is under 18 years old)**

**Witness Signature: _____Date: _____**

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# Coverage for Medical Emergencies During and After Hours

To ensure that all patients of Brighter Beginnings Family Health Clinics (BBFHC) have access to high quality care, we offer the following instructions to maintain patient coverage through medical emergencies that occur during and after clinic hours.

**Instructions:**

1. Patients are to call 911 if you feel that you have a situation in which medical services are required immediately to relieve severe pain or to diagnose and treat an unforeseen medical condition which, if not treated, would result in their disability or death.
2. Patients can call their clinic phone numbers and an advice nurse is available after hours to assist with any medical issues and will provide appropriate medical advice on next steps.
    a. Antioch: 925-303-4780
    b. Richmond: 510-236-6990
3. Patients who have CCHP are instructed that they can also call the CCHP after hours line at 1-877-661-6230 option 1. This after hours coverage is open 24 hours a day, 7 days a week.
4. If the patient needs to speak to the office staff regarding other matters such as scheduling, billing or other services, the patient will be instructed to call back during normal business hours.

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# INCOME AND FAMILY SIZE ATTESTATION

1. Applicant Name: _____ DOB: _____
2. Household* Size information (*Household members include those persons living in the same home who are related by birth, marriage, registered domestic partnership, or adoption.)

Please list below all members of your household, Including yourself.

| | Name | Relationship | Date of Birth | | Name | Relationship | Date of Birth |
|---|---|---|---|---|---|---|---|
| 1 | | | | 5 | | | |
| 2 | | | | 6 | | | |
| 3 | | | | 7 | | | |
| 4 | | | | 8 | | | |

3. Household* Income Information

Please list below all sources of income of all adult members of your household, including yourself. Adults are considered those persons 18 years or older. Please attach to this application verification of each source. See Appendix A, for examples of documents acceptable as proof of income.

| Name | Relationship | Source of Income | Amount Received | Frequently | Office use only Total |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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**Declaration:** Completion of the application and self-certification are necessary to participate in Brighter Beginnings services. I understand that Brighter Beginnings cannot guarantee services provided outside of Brighter Beginnings clinic to be free. I will be responsible for the bills incurred in receiving medical care not provided by Brighter Beginnings. If I am found eligible for other medical benefits I will need to apply or use coverage, as Brighter Beginnings provides services to those with no other resources or medical coverage.

**Date** **Printed Name** **Signature** **Relationship (If not applicant)**

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# SLIDING FEE DISCOUNT SCALE PROGRAM AGREEMENT

I agree that the following has been explained to me that I will follow all guidelines for this program. I understand that:

1. Services that are eligible under the programs such as CHIP (Children's Health Insurance Program), Family Planning, Breast and Cancer Screening, Medi-cal, Medicare and others are3 not covered under this program.

2. Only services that are medically necessary and ordered by staff of Brighter Beginnings are covered under this program.

3. Some in-office procedures may not be covered in this program. If the services are not covered, the billing staff will assist you to make arrangements.

4. Laboratory services, vaccinations & immunizations that are performed in our clinic are not covered under this program. Some medications prescribed by your medical provider may also be included if they are dispensed in-house. The clinic team strives to utilize the $4 Formularies and/or Patient Assistance Programs for medications, when possible.

5. The program may not cover services that are provided off-site at hospitals or other medical facilities.

6. I agree to notify Brighter Beginnings if I will miss an appointment 24 hours prior to scheduled appointment. If I do not present for a maximum of 3 scheduled appointments out notifying Brighter Beginnings, I may not be eligible to receive care at Brighter Beginnings anymore.

7. The effective date of my participation in this program is decided by the Brighter Beginning staff. Your enrollment is good for six months. If you have zero income your enrollment will expire in three months and you will be rescreened.

8. I agree to notify Brighter Beginnings if my income level or if the number in my household changes. Before it is time for renewal of my/or participation in the program.

9. I understand that I am required to bring in all documentation for proof of income for the household. I also understand that the staff of Brighter Beginnings may request verification of income at any time during my/our participation in the program.

10. **Payment of sliding fee scale fees is required at the time the service is received.**

Signature: _____ Date: _____

Print Name: _____

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# AUTHORIZATION TO CONTACT BY TELEPHONE/VERBALLY/LETTER IN EVENT OF BREACH OF PHI

I, _____, authorize Brighter Beginnings to provide notice to me by mailing a letter, telephone, or verbally in the event of a breach of my protected health information (PHI) by Brighter Beginnings. Such conversation shall be documented by Brighter Beginnings.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the letter, verbal, or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Brighter Beginnings.

This authorization is continuous even after I terminate services with Brighter Beginnings. I understand that I have the right to revoke this authorization at any time by writing to the Privacy Officer at 2727 Macdonald Ave, Richmond, CA 94804.

| Signature of Client | Print Name | Date |
|---|---|---|

| Print Name of Child (Child 1) | Print Name of Child (Child 2) | Print Name of Child (Child 3) |
|---|---|---|

| Signature of Parent/Guardian | Print Name | Date |
|---|---|---|

| Signature of BB Staff/Intern | Print Name | Date |
|---|---|---|

☐ Client is 18 years old or older ☐ Parent/Guardian is unavailable for signature

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# NOTICE OF PRIVACY PRACTICES:

# ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge the receipt of the Notice of Privacy Practices of Brighter Beginnings. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at www.brighter-beginnings.org or calling toll free at (877) 427-7134.

If you have any questions about or Notice of Privacy Practices, please contact:

Privacy Officer

Brighter Beginnings

2727 Macdonald Ave

Richmond, CA 94804

I acknowledge that I have received the Notice of Privacy Practices of Brighter Beginnings.

| Signature of Client | Print Name | Date |
|---|---|---|

| Print Name of Child (Child 1) | Print Name of Child (Child 2) | Print Name of Child (Child 3) |
|---|---|---|

| Signature of Parent/Guardian | Print Name | Date |
|---|---|---|

| Signature of BB Staff/Intern | Print Name | Date |
|---|---|---|

☐ Client is 18 years old or older ☐ Parent/Guardian is unavailable for signature

**Office/Staff Use Only**
☐ Client refuses to acknowledge receipt of Brighter Beginnings' Notice of Privacy Practices.

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# NOTICE OF ACKNOWLEDGEMENT ADVANCED DIRECTIVE

*Note: This form is only completed by adults 18 and older and emancipated youth.*

An Advance Directive is a legal document allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if he or she should lose decision making capacity. Advance Directives are the following written instruments: The Living Will and The Durable Power of Attorney for Health Care.

## The Living Will

Any adult person may, at any time, make a written declaration directing the withholding or withdrawal of life-sustaining procedures in the event such person should have a terminal and irreversible condition or is in a continual, profound comatose state with no reasonable chance of recovery.

## The Durable Power of Attorney

Any adult person may, at any time, through execution of a Durable Power of Attorney, designate another person to make treatment decisions for him/her in the event such person is usable to participate actively on his /her own behalf.

## Please read the following statements:

- I have been informed of my rights to formulate Advanced Directives.
- I understand Brighter Beginnings can provide me an Advance Directive form.
- I understand that I am not required to have an Advanced Directive in order to receive medical treatment at Brighter Beginnings.

## Please check the appropriate answer and sign below:

☐ **I HAVE** executed an Advanced Directive.

**Type:** ☐ Living Will ☐ Durable Power of Attorney

☐ **I HAVE NOT** executed an Advance Directive.

By signing this form, I acknowledge Brighter Beginnings has provided me information on Advance Directives.

Signature of Client Print Name Date

Attention to All of Our Patients:

We have limited appointment times available and in fairness to all of our patients, we started a new Cancellation Policy on July 1, 2016.

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**If you are unable to attend a scheduled appointment, we ask that you call our office at 24 business hours prior to your appointment time.** This will allow us to see another patient during your appointment slot.

After two "no shows" or late cancellations, you will be sent a final notice. After a third "no show" or late cancellation, we will only be able to see you one  asame day, space available basis.

We appreciate your cooperation and understanding.

Thank you,
Brighter Beginnings Family Health Clinic

I have read, received a copy, and understand this policy.

**Signature:** _____

**Printed Name:** _____

**Date:** _____

**MR# (staff use):** _____