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New Patient Welcome Packet

Pediatric 6-17 years

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Greetings,

Welcome to Orchid Health! Our Health Clinics were founded on the belief that our state's rural communities deserve to have extremely high quality healthcare that is local, comprehensive, and takes the time to address what matters most to each individual.

We have brought together the following care team members to provide individualized, comprehensive care:

Primary Care Provider (PCP): Your PCP will help you think through important health decisions and may connect you with another member of the care team to make sure that you are getting the best care.

Medical Assistant (MA): Your Medical Assistant will often be the first person you talk with when you have a health concern and will work closely with your PCP to help support any standard ongoing healthcare needs.

Nurse Care Coordinator (RN): At Orchid, we have nurses that help you design a personalized Care Plan, including identifying your personal health goals and planning for any upcoming preventive health items.

Behavioral Health Provider (BH): Our Behavioral Health Providers are available to help with any mental, emotional, or behavioral health needs that you may have. This may include making lifestyle changes, dealing with sadness or loneliness, or problems at home or school.

Community Health Worker (CHW): Our Community Health Workers are available to connect you with community resources, assist in navigating systems, help with insurance questions as well as help you advocate for your needs that can help improve overall health outcomes.

Enclosed are our new patient registration forms. Please complete these forms to the best of your knowledge. Included is a *Medical Records Release Form*, which allows us to request your past medical records prior to your first visit. We ask that you complete this form and drop it off at our clinic as soon as possible. Additionally, a *Controlled Substance Agreement* must be signed before the prescription of controlled substances by Orchid Health providers.

In order for us to best serve you:

1. Please check in at the clinic 15 minutes prior to your scheduled appointment time.
2. Please bring your insurance card and your ID with you to your visit.
3. Please bring the bottles of any current medications you are taking.
4. We require a 24-hour notice for cancellations.

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We are here to serve residents in our local rural community!
Welcome to the Orchid Health Family!

Oakridge: Clinic Phone number 541-782-8304

- We are located at 47815 Highway 58, Oakridge, right near the Pharmacy.
- Our hours of operation are: Monday and Friday from 8:30am-5pm, Tuesday, Wednesday and Thursday from 8:30am to 7pm. For after hours support, call our main clinic phone number.

Estacada: Clinic Phone number 503-630-8550

- We are located at 535 NE 6th Ave, Estacada, on the High School Campus, just to the right of the Estacada High School.
- Our hours of operation are: Monday from 8:30am to 5pm, Tuesday from 8:30am to 7pm and Wednesday, Thursday and Friday from 8:30am to 5pm. For after hours support, call our main clinic phone number.

McKenzie River: Clinic Phone number 541-822-3341

- We are located at 51730 Dexter Street, Blue River just off the McKenzie River Hwy
- Our hours of operation are: Monday through Thursday from 8:30am to 5pm. For after hours support, call our main clinic phone number.

Fern Ridge: Clinic Phone number 541-234-3255

- We are located at 24934 Fir Grove Lane, Elmira, located in the parking lot of the High School.
- Our hours of operation are: Monday, Tuesday and Thursday from 8:30am to 7pm and Wednesday & Friday from 8:30am to 5pm. For after hours support, call our main clinic phone number.

Sandy: Clinic Phone number 971-220-2701

- We are located at 37400 Bell Street, Sandy, located in the Student Health Center on campus.
- Our hours of operation are: Monday to Friday from 8:30am to 5pm. For after hours support, call our main clinic phone number.

Hoodland: Clinic Phone number: 971-333-0494

- We are located at 24461 E Welches Rd, Welches. Located next to the post office building.
- Our hours of operation are: Monday to Friday from 8:30am to 5pm. For after hours support, call our main clinic phone number.

FAQ - Frequently Asked Questions!

- **How do I make an appointment?**
  - Most people call our office to schedule an appointment.
  - You can also request an appointment through our Patient Portal.
- **Need to cancel your appointment?**
  - We require a 24-hour notice for cancellations.
- **What is the Patient Portal?**
  - The Portal allows you to send messages directly to your Provider, instead of calling. It also allows you to see any lab and imaging results as soon as we receive them.
  - You can find the portal link on our website: **www.orchidhealth.org** (upper right corner). Ask any of our staff for help. We can send you an email link or set you up when you come in.
  - Your health information will be available to you through our patient portal in English or Spanish. The patient portal is compatible with multiple screen reading technologies, including color blindness testing, to support accessibility for people with visual impairments
- **Calling the office?**
  - We strive to provide timely responses to requests. If you call the clinic, you should hear back from us within 24-48 business hours for non-urgent issues. If you send a portal message, you should receive a response within 2 business days.
- **What if I need to reach someone after the office is closed?**
  - Easy! Use the same phone number you normally call and listen for the option to reach our After-Hours Nurse Service.
- **How do I get my Prescription Refilled?**
  - The best FIRST step is to call your pharmacy and ask them for a refill - they will then contact us directly if needed.
  - If you are having any difficulty, please call us so we can resolve it for you. (Or use the Patient Portal!) Any "controlled medication RX" needs to be given during an appointment. (This would include things like pain medication, certain anxiety, or sleep medication, etc).
- **Can I have my blood tests done at Orchid?**
  - Yes, we draw labs for the patients who have *established* with us (even if ordered by other providers).
- **Do you do X-RAYS at Orchid?**
  - No, sorry, at this time, we do not have an X-RAY machine at any of our sites - but we can give you an order to do your test at your preferred imaging center.
- **How can I get my lab or X-RAY/imaging results?**
  - Most test results are shared on the patient portal. If you do not have a patient portal account, we will call you with the results. Some providers may coordinate reviewing your results during a scheduled visit. If you have questions, please reach out via the portal or call your clinic. We care here to help.
- **What if I am worried about paying for my visit or labs?**
  - We don't want money to stand in the way of your health care, so please talk to us about your concerns.
  - Ask about our Sliding Fee Discount, too!
- **Do you see Kids? What about Babies? What about Seniors?**
  - Yes, Yes, and Yes!
- **Patient Relations – How do I report a concern to Orchid Health?**
  - Patients or family members may report concerns about the quality of care, safety or service to any staff member, member of the medical staff or clinic manager. Patients or family members may also contact the Patient Relations Department listed below to share a compliment with staff.
  - Patient Relations – Orchid Health
  - Email: patientrelations@orchidhealth.org
  - Address: PO Box 546 Gresham OR 97030

ORCHID HEALTH REGISTRATION FORM - MINOR

(Please print)

Legal Name: _____ **Today's Date:** _____
First - Middle - Last

Preferred name that you go by: _____ **Preferred Pronouns:** _____

Legal Sex: Male/Female/Other **Date of Birth** (mm/dd/yyyy):_____ **Social Security Number:** _____

Parent/legal guardian #1 Name: _____ **Phone:** _____ **Lives with child:** ☐ Yes ☐ No

Parent/legal guardian #2 Name: _____ **Phone:** _____ **Lives with child:** ☐ Yes ☐ No

Physical Address: _____ **City:** _____ **State:** _____ **ZIP Code:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **ZIP Code:** _____

Home Phone: _____ **Mobile Phone:** _____ **Consent to text?** ☐ Yes ☐ No

Email:_____ **Preferred communication method:** _____ **Preferred Language:** _____

Race: (You can choose more than one if appropriate) ☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Hispanic or Latino Origin

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Other _____

Emergency Contact Name:_____ **Relationship:**_____ **Phone Number:**_____

INSURANCE INFORMATION

(please bring your insurance card to our receptionist)

Please indicate primary insurance name: _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

PERSON Financially Responsible for Bills and Payment:

Relationship to patient: _____ Name: _____ DOB: _____

Mailing Address: _____ ZIP Code: _____ City: _____ State: _____

Best Phone Number: _____

** VA PATIENTS ONLY, **MUST** fill in this section **

Policy Holders SS number or DBN number: _____ Name of Insurance: _____

CONSENT FORM - MINOR

Oregon state law requires a parent or legal guardian's consent to provide medical treatment to an individual under 15 years of age with the exception of 14-year-olds for sexual health and mental health services. *
*ORS 109.610, ORS 109.640, ORS 109.675.

I understand the following types of services are offered through Orchid Health:

- Routine physical exams, including sports physicals
- Early detection, diagnosis, and treatment of illness and injury treatment of minor injuries
- Management of Chronic Health Conditions
- Age-appropriate reproductive health
- Routine lab tests, Immunizations
- Prescription medications
- Mental health services
- Referral for health care services not provided by Orchid Health

I have read and fully understand the above information and have asked questions about anything not clear to me. I understand that I may revoke this consent at any time.

I (parent/legal guardian) _____give permission for my child, _____, to receive medical/mental health care at Orchid Health.

Authorization of Payment:

Parent or Guardian: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive and authorize the release of any medical records necessary to facilitate my child's treatment to process claims and as otherwise permitted or required in the Notice of Privacy Practices. I fully understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. ** SBHC's (School Based Health Clinic's), students receive care at no cost for Orchid Health Services.

Notice of Privacy Practices: I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice can be found on our website under patient forms, is available at the clinic upon check-in, and is otherwise available to me at any time upon request.

Patient Rights and Responsibilities: I acknowledge receipt of Orchid Health's Patient Rights and Responsibilities. These can be found on our website under patient forms, are available at the clinic upon check-in, and are otherwise available to me at any time upon request. I acknowledge receipt of information regarding Patient Rights and may accept or refuse care at any time. I understand I have the right to ask questions about and refuse these services. I acknowledge that I have the right to refuse care or withdraw my consent for care, without affecting my right to future care or treatment.

Consent to Access Historical Prescription/Pharmacy Records, and to Reach out to local Hospital Networks to Access Health History Information: I authorize the release of my child's historical health information, as accurate information is necessary for the provision of accurate and quality medical care.

Consent to Call: I consent to receiving calls from Orchid Health for my child's protected healthcare and other services at the phone number(s) provided to the practice, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Patient Name:_____ Patient DOB:_____ Today's Date:_____

Parent/Legal Guardian Signature _____ Relationship to Patient _____

AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name: _____ Date of Birth: _____

Authorization to Disclose Information to Others:

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.).

I give permission to release the following information to the individuals listed below:

- ❑ All health information about me created or received by Orchid Health, including medical records, case or medical management, billing, payment, claims and enrollment, mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

- ❑ All health information **except for**: mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

Name	Relationship	Phone Number

Personal Communication Methods:

As our patient, we may need to communicate with you outside of our clinic. To assure your privacy, we would like you to indicate whether it is OK or not to leave medical information (such as normal lab results) on a voicemail if we are unable to reach you.

Home Phone # _____

____ Do NOT leave messages
____ May leave call back numbers only
____ May leave messages with details

Mobile Phone # _____

____ Do NOT leave messages
____ May leave call back numbers only
____ May leave messages with details

TERM: This authorization will remain in effect for a period of **one year**. I can revoke this authorization in writing (at any time) as described in the Orchid Health Notice of Privacy Practices.

Patient or Authorized Representative Name (Please print): _____
Date of Birth _____
If authorized representative please state relationship to patient _____

Signature _____ Date _____

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Designation of Another Person to Consent for Minor Medical Care

If I, (parent/legal guardian) _____ , cannot accompany my child,

(child's name)_____ , to the Orchid Health Clinic, I give

permission to (person's name)_____ as follows (check one):

☐ I give permission for this person to seek medical treatment for my child (including any type of procedure) and provide consent for such treatment **without** having to contact me.

☐ I give permission for this person to seek medical treatment for my child (including any type of procedure) and provide consent for such treatment if attempts to contact me are unsuccessful.

☐ I give verbal permission to Orchid Health Staff for my child to seek medical treatment.

_____	_____	_____
Witness name (printed)	Witness Signature	Date

Expiration of Permission (check one):

☐ This form will remain in effect until revoked (by filling out a "revoke consent form")

☐ This form is VALID ONLY during the following time frame:

Effective date: _____ / Expiration date: _____

X _____ _____

(Signature of parent or legal guardian) (Date required)

Home Phone _____ Work Phone _____

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Medical Records Release

Patient Name_____ Former Name (if any) _____

D.O.B.: _____ Phone: _____

Address _____ City _____ State _____ Zip

I authorize information to be released FROM:	I authorize information to be released TO:
Name/Facility: _____	Name/Facility: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____

The purpose of this request is:

☐ Referred Medical Care ☐ Transferring Care ☐ Personal ☐ Legal ☐ Other _____

Type of information to be released:

☐ Complete Medical Records *(Consists of the last 2 years of treatment unless otherwise specified)*

☐ Other (Please specify): _____

MUST be INITIALED to be included with records

_____ HIV/AIDs related records _____ Mental Health related records _____ Genetic testing information

_____ Drug/Alcohol** ***PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

All records will be sent though fax unless otherwise indicated. I consent to the faxing of my medical records. All faxed documents contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot be guaranteed. ☐ YES ☐ NO

My signature indicates that I authorize the disclosure of the above information and understand the following:
I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment.
I understand I can cancel permission to use and disclose my information at any time in writing. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
I understand this change will not affect information that has already been shared.
I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/ AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.
I understand that I am allowed to receive a copy of this Authorization.

_____ _____ _____

Signature of Patient/Legally Responsible Person Relationship to Patient Date

☐ **Wade Creek Clinic**
535 NE 6th Ave • Estacada, OR 97023
F: (866) 669-3334 Ph: (503) 630-8550

☐ **Oakridge Clinic**
47815 Hwy 58 • Oakridge, OR 97463
F: (855) 313-2095 Ph: (541) 782-8304

☐ **Fern Ridge Clinic**
24934 Fir Grove Ln • Elmira, OR 97437
F: (833) 673-0252 Ph: (541) 234-3255

☐ **McKenzie River Clinic**
51730 Dexter Street • Blue River, OR 97413
F: (833) 905-2303 Ph: (541) 822-3341

☐ **Sandy Clinic**
37400 Bell St • Sandy, OR 97055
F: (833) 903-3607 Ph: (971)220-2701

☐ **Hoodland Clinic**
24461 E Welches Road • Welches, OR 97067
F: (833) 973-4292 Ph: 971-333-0494

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ORCHID HEALTH MARKETING CONSENT FORM

How did you hear about us? (Please check one or provide details if not listed):
[ ] Online search
[ ] Word of Mouth
[ ] Social media
[ ] Print advertisement
[ ] Saw a Sign
[ ] Other: _____

I, _____, hereby grant consent to Orchid Health to send me marketing communications via email. I understand that I have the right to "opt out" of receiving such communications even if I have signed the opt-in option.

I understand and acknowledge the following:
1. Purpose: Communication that encourages you to use our services is considered marketing. We must obtain your authorization. The marketing communications may include information about Orchid Health services, promotions, events, newsletters, and other related healthcare materials.
2. Voluntary Participation: I have the right to choose whether or not to receive marketing communications from Orchid Health. Participation is entirely voluntary.
3. Privacy: Orchid Health will handle my personal information in accordance with its privacy policy and applicable laws and regulations.

Consent Options:
Please indicate your preference by checking the appropriate box below:

[ ] I consent to receive marketing communications from Orchid Health via email.
[ ] I do **NOT** wish to receive any Marketing Communications from Orchid Health.

Patient or Authorized Representative Name (Please print): _____
Date of Birth _____
If authorized representative please state relationship to patient _____

Signature _____Date _____

Nondiscrimination and Accessibility Statement:

Discrimination is Against the Law

Orchid Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Orchid Health does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Orchid Health:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Compliance Manager.

If you believe that Orchid Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- The Compliance Manager
- PO BOX 546 GRESHAM, OR 97030
- patientrelations@orchidhealth.org
- 541-246-7133

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at Orchid Health's website: www.orchidhealth.org

New Patient Health History - Pediatric 6-17 years

Name _____ **Date of Birth** _____ **Today's Date** _____

Current Medical Concerns (what you would like to talk about today):

_____

_____

Please list any allergies you have to medications:
NAME OF MED Reaction

_____

_____

Please list any medications you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:
NAME OF MED Dose Directions (How often given)

_____

_____

Immunizations
Do you follow the recommended CDC vaccination schedule? ❒ Yes ❒ No

Please explain if altering schedule: _____

Any hospitalizations? ❒ Yes ❒ No ❒ If yes, please explain below:

_____

_____

Please circle any surgeries: ❒ Heart ❒ Ear Tubes ❒ Tonsils/Adenoids ❒ Appendix ❒ Circumcision ❒ Frenulectomy (tongue clipping) ❒ Eye Surgery ❒ Hernia Repair, type: _____ ❒ Other: _____

For ages 12-17 only Who is filling out this portion of the form?

_____ Sexually Active? ❒ Yes ❒ No If Yes, number of total partners (past and present): _____ If YES, do you use condoms always? ❒ Yes ❒ No

Do you use another form of Birth Control or Contraception? ❒ Yes ❒ No

Menstrual Periods started at age _____ Date of Last Menstrual Period _____

_____ Any past pregnancies? ❒ Yes ❒ No

FAMILY HEALTH HISTORY

Are you adopted? ❒ Yes ❒ No (If NO, please complete section below) P=Paternal M=Maternal

	Mother	Father	Grandma	Grandpa	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism/Substance Abuse								
Aneurysm								
Anxiety and/or Depression								
Arthritis								
Asthma								
Bipolar or Schizophrenia								
Blood Disorder								
Cancer								
Diabetes								
Emphysema/COPD								
Heart Attack								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Migraines								
Osteoporosis								
Seizures								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

PERSONAL HEALTH HISTORY

ADHD or ADD	❒ Yes	❒ No	Endometriosis	❒ Yes	❒ No
Alcoholism/Substance Abuse	❒ Yes	❒ No	Fibromyalgia	❒ Yes	❒ No
Allergies/Hay fever	❒ Yes	❒ No	Gout	❒ Yes	❒ No
Anemia	❒ Yes	❒ No	GYN Problems	❒ Yes	❒ No
Anesthesia Complications	❒ Yes	❒ No	HIV	❒ Yes	❒ No
Anxiety Disorder or Recurrent Anxiety	❒ Yes	❒ No	Heart Problems	❒ Yes	❒ No
Arthritis	❒ Yes	❒ No	Hepatitis C	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	High Blood Pressure/Hypertension	❒ Yes	❒ No
Autism Spectrum Disorder	❒ Yes	❒ No	High Cholesterol	❒ Yes	❒ No
Bipolar or Schizophrenia	❒ Yes	❒ No	Kidney Stones	❒ Yes	❒ No
Birth Defects or Inherited Disease	❒ Yes	❒ No	Kidney or Bladder Problems	❒ Yes	❒ No
Blood Transfusion	❒ Yes	❒ No	Liver Disease	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Migraines	❒ Yes	❒ No
Chicken Pox	❒ Yes	❒ No	Muscle, Joint, or Bone Problems	❒ Yes	❒ No
Clotting Problems/bleed too much	❒ Yes	❒ No	Osteoporosis	❒ Yes	❒ No
Depression	❒ Yes	❒ No	Reflux/GERD	❒ Yes	❒ No
Developmental or Behavioral Disorders	❒ Yes	❒ No	Seizures/Epilepsy	❒ Yes	❒ No
Diabetes or Pre-Diabetes	❒ Yes	❒ No	Skin problems (Rashes/Changing Moles)	❒ Yes	❒ No
Diverticulitis/Diverticulosis	❒ Yes	❒ No	Stomach Ulcers or Swallowing Problems	❒ Yes	❒ No
Domestic Violence	❒ Yes	❒ No	Stroke or TIA	❒ Yes	❒ No
Ear Infections - Chronic	❒ Yes	❒ No	Thyroid Problems	❒ Yes	❒ No
Ear or Hearing Problems	❒ Yes	❒ No	Tuberculosis or Positive TB Test	❒ Yes	❒ No
Eating Disorder like Anorexia or Bulimia	❒ Yes	❒ No	Vision or Eye Problems	❒ Yes	❒ No
Eczema	❒ Yes	❒ No	Other:	❒ Yes	❒ No
Emphysema/COPD/Chronic Bronchitis	❒ Yes	❒ No			

As part of whole person care offered at Orchid Health, we have Community Health Workers (CHWs) available to support you with connection to resources beyond the medical clinic.

Name _____ DOB _____ Today's Date _____

1. **What is something that makes you happy or that you're proud of?**

   _____

2. **Do you currently live in a shelter or have no steady place to sleep at night?**

   ❒ Yes ❒ No

3. **Do you think you are at risk of becoming homeless? OR at risk of facing eviction?**

   ❒ Yes ❒ No

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**

   ❒ Often true ❒ Sometimes true ❒ Never true

5. **Within the past 12 months, you worried whether your food would run out before you got money to buy more.**

   ❒ Often true ❒ Sometimes true ❒ Never true

6. **Do you have trouble getting transportation to medical appointments?**

   ❒ Yes ❒ No

Please indicate if you have concerns about any of the following:


❒ Alcohol/Substance Use


❒ Child or Elder Care


❒ Clothing


❒ Dental Care


❒ Education

❒ Employment


❒Health Insurance


❒ Pests / Mold / Air Quality


❒ Prescription Costs


❒ Social Connection


❒ Utility Costs


❒ Vision Care

Would you like assistance with any of the above areas? ❒ Yes ❒ No ❒ Not Sure

Patient Consent Form for AI Scribe Recording

To support our mission of providing high quality care, we are using a new technology which uses artificial intelligence and associated workflows to generate documentation based on recorded audio of patient visits. This technology significantly reduces the amount of time your clinician spends on documentation and allows more time to provide care for you and other patients. All documentation is reviewed, corrected, and approved by your clinician to ensure the accuracy and completeness of your medical record.

We ask for you to sign this form to indicate your consent to have your visit recorded and processed for the purpose of documenting your care. I acknowledge that my health care information is sensitive and confidential. I consent to the recording and documentation of my healthcare visits under the condition that appropriate measures are in place to safeguard the privacy and security of my medical information.

This consent is voluntary, and your care will not be conditioned on providing consent.

Please read the statement below carefully and sign to indicate your consent or to opt-out.

☐ I hereby consent to the recording of my visit today as well as any future visits. I understand that I may revoke my consent to the recording of future visits at any time.

☐ I hereby do not consent to the recording of my visit today and choose to opt-out

Patient Name (Printed) Patient Date of birth

Signature of Patient or Personal Representative

If signed by other than patient: PRINT representative name and relationship to patient

Today's Date