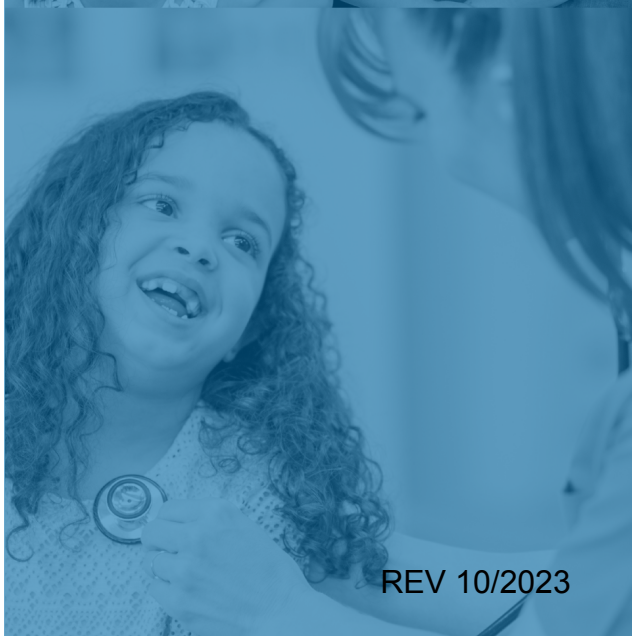
New Patient Health Care Forms

Welcome to Axis Community Health! Our mission is to provide quality, affordable, accessible and compassionate health care services that promote the well-being of all members of the community. We offer health services to meet all of your needs. Our staff looks forward to being your partner in helping you stay healthy. **To view our Patient Handbook please scan the code with your phone or ask for a copy at the front desk:**



Inside you will find the following forms:

- Acknowledgment of New Patient Information
- Acknowledgment of Receipt of Notice Of Privacy Practices
- Informed Consent for Treatment
- Informed Consent for Behavioral Health
- Informed Consent for Telehealth Appointments
- Authorization for Release and/or Disclosure of Behavioral Health Information
- Advance Health Care Directive

REV 10/2023

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ACKNOWLEDGMENT OF NEW PATIENT INFORMATION

MR#:_____

PCP:_____

Use your phone's camera and point it to the code on the right to view the Patient Handbook, or ask for a copy at the front desk:

I have read and understand the terms of the following documents:

- Information on locations, making appointments, services, prescriptions, referrals, and other important information on getting health care at Axis
- Acknowledgment of Receipt of Notice of Privacy Practices
- No-Show Policy
- Patient Rights & Responsibilities
- Notice of Privacy Practices

Please review all of this important information regarding your care.

I acknowledge that I have received all the above information:

Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Staff Initials: _____

File in chart (Financial Section)

AXIS COMMUNITY HEALTH

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices (NPP) of Axis Community Health. The NPP provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full NPP. If you have any questions about our NPP that our registration staff cannot answer, please contact our Privacy Officer at (925) 201-6211, or send a written inquiry to the Compliance Office, 5925 W. Las Positas Blvd., Suite 100, Pleasanton, CA 94588.

_____
Name of Patient/Client (print)

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Patient/Client Representative Date
(Required if Patient/Client is a minor or an adult who is unable to sign this form)

_____
Patient/Client Representative Print Name

_____
Patient/Client Representative: Indicate Relationship to Patient

FOR OFFICE USE ONLY

If Axis is not able to obtain the patient's written acknowledgment, record the good-faith effort made to obtain acknowledgment and the reason written acknowledgment could not be obtained:

Effort to obtain acknowledgment:

- ☐ In-person request
- ☐ Request via mail
- ☐ Request via email
- ☐ Other:_____

Reason acknowledgment was not obtained:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Patient did not return acknowledgment via mail or email
- ☐ Other:_____

Employee Signature:_____ Date:_____

Employee Print Name:_____

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INFORMED CONSENT FOR TREATMENT

I hereby authorize Axis Community Health affiliated physicians, providers and staff to administer medical treatment which may now or during the course of care be deemed advisable or necessary.

I acknowledge that I am legally responsible for all charges in connection with medical care and treatment provided by Axis Community Health. Treatment charges may include, but are not limited to, provider visits, nurse visits, lab tests, medications, supplies, and equipment.

I am also responsible for understanding my insurance and/or health care program coverage and restrictions and for immediately notifying Axis Community Health whenever there is a change in information necessary to process the claims.

I understand that I have a right to file a complaint/grievance if I am not comfortable with medical decisions that directly affect me. I have the right to appeal to supervisory staff or the Chief Operating Officer.

I understand that I have a right to file grievance directly with regulatory agencies even if I have not filed a grievance with Axis. My decision to file a complaint/grievance will not compromise my care. All information regarding the grievance/complaint will be kept confidential.

Patient / Representative Signature:_____ **Date**:_____

If signed by someone other than the patient:

Representative Print Name:_____

Representative Relationship to Patient:_____

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BEHAVIORAL HEALTH SERVICES INFORMED CONSENT

Welcome to Axis Behavioral Health Services, where we provide support to adults, adolescents and children through assessment and counseling services using evidence-based approaches and qualified staff. Our mental health counselors are licensed therapists, psychologists or masters' level mental health interns who are here to provide you with tools and techniques to address current struggles.

Axis manages a training/internship program. All interns are masters' level, have received adequate training to conduct services and are supervised by licensed practitioners. Axis Community Health's training program involves that confidential use of client information as necessary for training purposes.

As you enter into any of our behavioral health services, you will receive an intake assessment. The intent of the intake is to determine diagnosis, and appropriateness for our services. If we cannot provide you with the most appropriate services, we will recommend an agency that can better meet your needs.

Freedom of choice: We will inform you about our recommendations for your care, so that your decision to participate is made with knowledge and is meaningful. In addition to having the right to stop series at any time, you also have the right to refuse to use any recommendations, interventions or treatment procedures. Your participation in our services is voluntary and is not a requirement for access to other community services. You have the right to access other behavioral health services funded by Medi-Cal or Drug Medi-Cal and have the right to request a change of provider and/or staff.

Intake sessions range from 45 min to 90 minutes on average and may take place over the course of a couple of meetings. Our individual sessions are 30 minutes and occur at a frequency determined by your counselor and will occur over a six-month period (unless otherwise determined by your provider).
We also provide some group counseling services that are 60-90 minutes in length.

There are pros and cons to obtaining behavioral health services. For example, while these services may be helpful in alleviating current mental health or addiction struggles, it is sometimes difficult to be open and honest throughout the process, and the process can at times feel revealing. Our behavioral health services are offered during weekdays; however, if it is after hours or a weekend, and you are in crisis, please call the **Alameda County Crisis Line at 800-309-2131**.

Grievance and Referrals

If you think decisions that affect you directly are unfair, you have the right to appeal to supervisory staff, the Program Director, Site Director and Chief of Behavioral Health if necessary. We recommend that you start with your therapist, counselor or Program Director.

Your grievance will be kept confidential and will not compromise the care you receive.

You also have the right to file a complaint with regulatory agencies, even if you have not filed a grievance with Axis. One such regulatory agency for mental health counseling is the Alameda County Grievance and Appeal line at 800-734-2504. Specific information is also located on corresponding posters in the waiting room.

The Alameda County Member Handbook and Provider List are available for reference in the waiting room, which includes other services that are offered to Medi-Cal patients and information about how to access them.

Notice of Sliding Fee Scale

If you have difficulty paying for your services at Axis, we do offer sliding scale discounts for eligible low-income persons. To learn more, please see our Patient Services Department or the Front Desk. No one will be denied healthcare, or behavioral health services, based solely on their inability to pay.

Team Based Care and Electronic Health Records

At Axis Community Health, you are taken care of by a multidisciplinary team which includes your medical provider(s) and your behavioral health care provider(s). Other members of your care team may include a registered dietitian, registered nurses, mental health professionals and interns, and support staff. As part of your team-based care, your care team may share information about your case with one another to ensure that you receive the best care.

Your care team may access your health information and may view or share this information with other members of your care team. This allows for the full coordination of your care and assists us in addressing all of your needs from a patient-centered and whole-person aspect. One of the ways your care team communicates and tracks your treatment is through the use of an electronic health record system. As part of this system, your care team has the ability to access information regarding your treatment progress at Axis.

Confidentiality

What you tell your providers and care team at Axis is confidential and protected by the Health Insurance Portability and Accountability Act (HIPAA) and the California Confidentiality of Medical Information Act (CMIA). However, there are some situations where your providers may be legally required to disclose information. These are referred to as "mandatory reporting" laws. First, a provider is obligated to disclose confidential information when necessary to protect an individual's safety (for example, if there is reason to believe the patient may hurt themselves or someone else). Second, if there is reason to believe that a child (someone under 18), an elderly person (someone over 60), someone who is disabled, or someone who lives in certain residences, such as a nursing home, is being abused, neglected, or financially exploited, the provider is legally obligated to disclose this information to a state agency. Axis also participates in the OCHIN/EPIC Health Information Exchange (HIE), a system that allows health care professionals and patients to appropriately access and securely share a patient's medical information electronically. For more information, please refer to Axis's Notice of Privacy Practices (NPP).

I acknowledge that I have read this document and have had the opportunity to have my questions answered. I give my consent to Axis Community Health to render behavioral health services to me.

Patient / Representative Signature: _____ Date: _____

If signed by someone other than the patient:

Representative Print Name: _____

Representative Relationship to Patient: _____

110.37.2

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INFORMED CONSENT FOR TELEHEALTH APPOINTMENTS

1. I understand that my provider will be at a different location from me when we connect for our appointment.

2. I will be informed if any additional personnel, like a translator, will be present during the telehealth appointment. I will give my verbal permission before the entry of the additional personnel.

3. The provider will keep a record of the telehealth appointment in my medical record.

4. RELEASE OF INFORMATION: I understand that Axis Community Health is authorized to furnish medical information from my medical record to a referring physician, if any, and to any insurance company or third-party payer to obtain payment of the account. Axis Community Health is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.

5. I voluntarily consent to health care services provided by my doctor(s) or a designee, which may include diagnostic tests, drugs, and examinations.

6. I understand that I have the option to refuse telehealth service at any time without affecting the right to future care or treatment and without risk of losing benefits. I do not have to answer any questions that I am unwilling to have heard by other persons or do not feel comfortable answering.

7. I understand that if I do not choose to participate in a telehealth session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation. I understand that as with any technology, telehealth does have its limitations. There is no guarantee, therefore, that this telehealth session will eliminate the need for me to see a provider in person.

Patient/Representative Signature: _____

Date: _____

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AUTHORIZATION FOR RELEASE AND/ OR DISCLOSURE OF BEHAVIORAL HEALTH INFORMATION

INSTRUCTIONS: Please review and complete this form carefully. This form will be processed by medical records. Please mail or hand deliver this completed form to the following address: Axis Community Health, ATTN: Medical Records, 4361 Railroad Avenue, Pleasanton, CA 94566 or via fax at (925) 462-1650

PATIENT'S INFORMATION		
Name:	Axis Medical Record #:	
Birthdate:	Phone Number:	Request Date:
Address:		
PHI MAY BE DISCLOSED BY:		
Person (Name or Title):	Facility or Program Name:	
Address:	Telephone:	Fax #:
PHI MAY BE DISCLOSED TO:		
Facility or Program Name	Name of Recipient Required if relationship to patient is 'Other'.*	Relationship to Patient
		☐ Treating Provider ☐ Third-Party Payer ☐ Other (Add name of recipient*)
Address:		

Method of Disclosure:

☐ Mail:_____

☐ Email:_____

☐ Fax:_____ ☐ Phone:_____

☐ Other:_____

Will information be shared both ways between the two parties mentioned above?

☐ Check if yes

PHI USAGE

By signing this form, I authorize the use and disclosure of the requested protected health information to be used for the following purposes:

PERSONAL HEALTH INFORMATION TO BE DISCLOSED

☐ Mental Health, or Drug & Alcohol Program: Initial Assessment/Intake, Treatment Plans, Diagnosis, Discharge Plan

☐ Psychiatric Evaluation, psychiatric medications, psychiatric intake and discharge forms

☐ Results of Psychological Testing or Screening

☐ DUI attendance and participation, progress and recommendations for treatment

☐ Other: _____

NOTE: Behavioral health records are typically released to other agencies for the purpose of coordination of care, or to verify completion of treatment. Behavioral health records requested to be released to the patient directly will undergo an internal review process. Hospital and Medical records being sent to Axis may include disclosure of mental health, alcohol/drug information as a part of this authorization.

The treatment records for mental health, or alcohol/drug departments are specifically protected, and will not be disclosed unless you sign below.

☐Alcohol/Drug Records ►Signature: _____

☐Mental Health Records ►Signature: _____

Provider Approval Signature Required: _____

Provider Name: _____ Date: _____

Disclosures: As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), 42 CFR Part 2 and California law, this practice may not use or disclose your individually identifiable health information, except as provided in our Notice of Privacy Practices, without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described herein. The exceptions are set forth in the Notice of Privacy Practice and Informed Consent Documents.

I also understand that violation of the federal law and regulations by a part 2 program is a crime and that suspected violations may be reported to the appropriate authorities consistent with section 2.4, along with the contact information. For Alameda County, Northern Judicial District in California, the contact information is: United States Attorney's Office Federal Courthouse, 1301 Clay Street, Oakland, CA 94612; Phone: 510-637-3724.

Right to Revoke: I understand that my Representative or I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that occurred before Axis Community Health received and processed a written notice of revocation. I understand that if I do not revoke the authorization, this authorization will expire one year from the date of signature below. Note: If this authorization is for a minor, the expiration date cannot exceed the 18th birthday of that minor. To revoke this authorization, I understand that I must send a written request to Axis Community Health, ATTN: Clinic Operations Manager, 4361 Railroad Avenue Pleasanton, CA 94566 or via fax at (925) 462-1650.

List of Disclosures: You have a right to obtain a list of entities that received your information in the previous two years under a general designation consent. You must submit this request in writing to the address noted above.

Effect of Refusal to Sign Authorization: This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

ACKNOWLEDGMENT

I authorize the disclosure of my personal health information to the persons/entities as described. I understand this authorization is voluntary, and made to confirm my directions. I understand that if an electronic copy of information is requested, it can be produced in the form requested if it is readily producible. If disclosure is requested to be sent by email or "other" method, I understand that email addresses and "other" methods can be accessed by others who may or may not be authorized by me to view my nonpublic health information and I indemnify Axis Community Health from such unintentional disclosure. I further understand that I have a right to receive a copy of this authorization form. I hereby give permission to Axis Community Health and/or the person/facility indicated on this form to disclose, release and use my personal health information in the manner described herein.

By: _____ _____

Patient's Name (Print) Patient's Signature Date

If you are not the patient, please also complete, sign and date below. Check the box that describes your relationship to the patient. Please attach proof or your relationship to the patient (e.g. Power of Attorney, legal guardian) if we do not currently have this on file.

By : _____ _____

Representative's Name (Print) Representative's Signature Date

- ❑ Parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient
- ❑ Spouse or person financially responsible (where information is solely for purpose of processing application for dependent health care coverage)

Authorization Tracking Information

For Axis Use Only:	
Date received:	Processed by:
Completion Date:	File Date:

Advance Health Care Directive Form Instructions

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decisions for you.

The Advance Health Care Directive form lets you do one or both of these things. It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

INSTRUCTIONS

Part 1: Power of Attorney

Part 1 lets you:

- **name** another person as **agent** to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
- **also name** an **alternate agent** to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Your **agent** may not be:

- an operator or employee of a community care facility or a residential care facility where you are receiving care.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes.

You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.

Part 3: Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, **sign and date it** in the section provided.

The form must be signed **by two qualified witnesses** (see the statements of the witnesses included in the form) **or** acknowledged before a notary public. **A notary is not required if the form is signed by two witnesses. The wittnesses must sign the form on the same date it is signed by the person making the Advance Directive.**

See part 6 of the form if you are a patient in a skilled nursing facility.

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form ***if you are a patient in a skilled nursing facility*** (a health care facility that provides skilled nursing care and supportive care to patients). See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time

If you have questions about completing the Advance Directive in the hospital, please ask to speak to a Chaplain or Social Worker.

We ask that you
complete this form in English
so your caregivers can understand your directions.

Advance Health Care Directive

Name_____

Date_____

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

ALTERNATE AGENT (Optional): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as alternate agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

SECOND ALTERNATE AGENT (optional): If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, 2) to choose a particular physician or health care facility, and 3) to receive or consent to the release of medical information and records, except as I state here:

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial the following line.

If I initial this line, my agent's authority to make health care decisions for me takes effect immediately. ____

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named. _____ (initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ a) Choice Not To Prolong
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.

Or

☐ b) Choice To Prolong
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

_____

_____

_____

_____

_____

Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts

☐ I give the following organs, tissues or parts only:_____

☐ I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):

Transplant Therapy Research Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician:_____

Address: _____

_____

Telephone: _____

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign name: _____ Date: _____

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate on his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OF OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code:

Print Name:_____ Signature: _____

Address: _____ Date: _____

Certificate of Acknowledgment of Notary Public (Not required if signed by two witnesses)

State of California, County of _____ On this _____ day of _____ , _____ , before me, the undersigned, a Notary Public in and for said State, personally appeared _____ , personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed it.

WITNESS my hand an official seal. Seal

Signature_____