



PATIENT REGISTRATION FORM

Updated 1.2026

ENTER PATIENT INFORMATION BELOW

First Name: _____ Last Name: _____ Middle Name _____

Preferred Name (if different): _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Cell Home / Email Address: _____

Marital Status: Single Married Divorced Widowed Partner Legally Separated Choose not to disclose

INSURANCE INFORMATION: Are you insured? Yes No. If "Yes," Insurance Plan Name: _____

Member ID Number: _____ Medi-Cal Medicare Commercial Other: _____

INCOME INFORMATION: We collect household income and family size from all patients. Patients will not be denied services based on income or ability to pay. Total number of persons in your household: _____

Estimated family household income: \$ _____ per Yearly Monthly Bi-Weekly Weekly

EMERGENCY CONTACT: (for Adult patient, or Responsible Party if patient is a Minor)

Emergency Contact Name: _____ Phone Number: _____

Relationship to patient: Spouse Mother Father Grandparent Other: _____

Preferred contact method: Phone Call Text Message Email Do not leave messages

ADVANCE DIRECTIVE: Do you have an Advance Directive on file? Yes No Would like more information

PATIENT DETAILS: The following questions help us provide appropriate care and meet reporting requirements.

Sex Assigned at Birth: Female Male Choose not to disclose

Gender Identity: Female Male Transgender Male / Female-to-Male Transgender Female / Male-to-Female
 Other: _____ Choose not to disclose

Sexual Orientation: Straight (not lesbian or gay) Lesbian or Gay Bisexual Something else Don't know
 Choose not to disclose

LANGUAGE & INTERPRETER SERVICES: Do you need free interpreter services? Yes No

Primary Language: English Spanish Other: _____

HOUSING STATUS: Where do you currently live? In my home At a shelter Staying with others
 The street, a camp, under a bridge, or in a car In transitional housing Choose not to disclose

RACE & ETHNICITY: Ethnicity Hispanic / Latino Non-Hispanic / Latino Choose not to disclose

Race Asian American Indian (North, Central, and South America) Black or African American White
 Native Hawaiian or Other Pacific Islander Choose not to disclose

VETERAN STATUS: Are you a veteran? Yes No Choose not to disclose

SIGNATURE: By signing below I confirm that the information provided is accurate and complete to the best of my knowledge.

Patient/Parent/Guardian Name: _____ Signature: _____ Date: _____

If signing for a minor, relationship to minor: _____

Patient Name: _____ DOB: _____

TREATMENT CONSENT

By signing this form, you voluntarily consent to receive medical, behavioral health, and/or dental services from UMMA Health, including examinations, diagnostic tests, treatments, and procedures recommended by your care team. You understand that you may refuse or withdraw consent at any time and that no guarantees are made regarding outcomes.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS

UMMA Health is a Federally Qualified Health Center (FQHC) supported by HRSA Section 330 funding. UMMA will not deny services due to inability to pay and offers a Sliding Fee Discount Program.

Your Responsibilities

- Payment of applicable co-payments, deductibles, or coinsurance
- Payment for services if uninsured or out-of-network
- Providing accurate insurance, income, and household information

Sliding Fee Discount Program - Discounts are based on household size and income. Proof of income is required and must be updated annually or when circumstances change. Insurance and Billing - You authorize UMMA Health to bill your insurance and assist with public coverage applications as permitted by law.

NOTICE OF PRIVACY PRACTICES (HIPAA)

UMMA Health is required by law to protect the privacy of your health information and to provide you with a Notice of Privacy Practices. This notice explains how your information may be used for treatment, payment, and health care operations; your rights regarding your health information; and UMMA Health's legal duties. You may request a copy of the Notice of Privacy Practices at any time or email questions@ummaclinic.org for a copy.

NON-DISCRIMINATION NOTICE

UMMA Health complies with federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex, including sexual orientation and gender identity. UMMA Health provides free aids and services for individuals with disabilities and free language services for individuals with limited English proficiency. If you believe you have experienced discrimination, you may file a grievance with UMMA Health or the U.S. Department of Health and Human Services.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) AND Health Information Exchange (HIE)

UMMA Health may use and disclose your protected health information for treatment, payment, and health care operations as permitted by HIPAA and applicable law. UMMA Health participates in a regional HIE, including the Los Angeles Network for Enhanced Services (LANES). Participation in the HIE is voluntary. You have the right to opt out of having your information shared through the HIE at any time. To opt out or to change your HIE participation status, please request a LANES Patient Change of Consent Form from UMMA Health staff.

E-PRESCRIBING CONSENT

UMMA Health uses electronic prescribing systems to transmit prescriptions directly to pharmacies and to review medication history for patient safety. Information may be shared with pharmacies and payers as permitted by law. You may withdraw consent for electronic prescribing at any time.

LANGUAGE ASSISTANCE / INTERPRETER SERVICES NOTICE

UMMA Health provides free language assistance services, including qualified interpreters and translated materials, for patients with limited English proficiency or hearing impairments. Interpreter services are available at no cost and may be requested at any time during your visit or care.

You may decline interpreter services if you choose.



CONSENT & NOTICE PACKET

Patient Name: _____ DOB: _____

CONSENT FOR PATIENT REMINDERS & NOTIFICATIONS

UMMA Health may contact you by text message, voice call, email, or patient portal for health-related communications such as appointment reminders, prescription notifications, lab results, and preventive care messages. Message frequency varies. Standard message and data rates may apply. Messages are sent through secure vendors such as eClinicalWorks and Healow. No marketing messages will be sent. Electronic communications may not be fully secure. By consenting, you accept this risk. You may opt out of text messages at any time by replying STOP or by contacting UMMA Health.

TELEHEALTH / TELEMEDICINE CONSENT

Purpose - UMMA Health offers telehealth services, which may include video visits, phone visits, secure messaging, and remote review of health information. **What Telehealth Involves** - Telehealth services may include evaluation, consultation, diagnosis, and treatment using audio, video, or electronic communications. Medical information may be exchanged with other health professionals as needed for your care. **Benefits** - Telehealth may improve access to care, reduce travel time, and allow timely follow-up. **Risks and Limitations** - Telehealth services may be affected by technical failures. Electronic communications may pose privacy risks despite safeguards. Telehealth may not be appropriate for all conditions, and an in-person visit may be required. **Alternatives** - You may request an in-person visit at any time.

FOR ADULT PATIENTS – PATIENT SIGNATURE

By signing below, I acknowledge that I have read and understand the information in this consent and notice packet, and I agree to the terms described above.

Full Name: _____ Signature: _____ Date: _____

COMPLETE FOR MINORS ONLY

PARENT / LEGAL GUARDIAN CONSENT & CAREGIVER AUTHORIZATION

By signing below, I certify that I am the parent or legal guardian of the minor and have the legal authority to consent to care and acknowledge all notices contained in this consent packet.

Parent / Legal Guardian Information Signature

Parent / Legal Guardian Name: _____ Relationship to Minor: _____
Signature: _____ Date: _____

Additional Authorized Caregivers (Optional)

I further authorize the adult(s) listed in the patient registration record to accompany my child to UMMA Health for purposes of registration, check-in, communication, and receipt of routine medical, dental, and/or behavioral health services, as permitted by law, when I am unable to be present (Note: UMMA Health may require additional consent or documentation for certain services.)

1. Name of Person: _____ Relationship to Minor: _____ Phone Number: _____
2. Name of Person: _____ Relationship to Minor: _____ Phone Number: _____