Free Clinic of Simi Valley
Face Sheet

DATE:

Patient Name: _____ DOB: _____ Age: _____ Gender: M/F

Address: _____
City: _____ State: _____
Zip code: _____ County: _____

Telephone: _____ Spouse/Guardian: _____

Email address: _____

Emergency Contact (Name, Phone Number, Relationship)

_____

Social Security Number: _____

Referred By:
Dental Clinic
Drive By
Family
Friend
Medi-Cal
Prison
Quest Diagnostics
Samaritan Center
Simi Valley Adult School
Simi Valley Hospital
Los Robles Hospital
St. John's Hospital
Conejo Free Clinic
Other_____

Race:
Caucasian
Black
Asian
Native American
Pacific Islander
Other

Ethnicity:
Hispanic or Latino
Not Hispanic
Unknown

Marital Status:
Single
Married
Separated
Divorced
Widowed

Education:
Grade School
Some High School
High School
GED
Some College
College Degree
Graduate Degree
None

Veteran:
Yes
No

Language:
_____

Employer:
_____

Household Yearly Income:

Housing:
Apartment
Private Home
Public Shelter
Stay with a Friend or Family
Street Trailer

Employment:
Unemployed
Disabled
Full Time
Part Time
Retired
Seasonal
Student

Number of Dependents in Household:

Health Coverage:
Medi-Cal
Medi-Care
Private Insurance
Covered California
None

Please circle your answers and answer all questions – Thanks!

NOTICE OF PRIVACY OF PRACTICES
FACT SHEET

THIS NOTICE BRIEFLY DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE FREE CLINIC OF SIMI VALLEY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. (Protected health information is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.) PLEASE REVIEW THIS NOTICE CAREFULLY. ATTACHED IS A MORE COMPLETE DESCRIPTION OF THIS INFORMATION.
If you have any questions about this notice, please contact our COMPLIANCE COORDINATOR at 522-3733

We are required by law to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

For Treatment
For Payment
To Individuals Involved in Your Care or Payment for Your care
To Determine Treatment Alternatives
For Health-Related Benefits and Services
For Health Care Appointment Reminders
To Coroners or Medical Examiners
For National Security and Intelligence Activities
As Required By Law Enforcement
Military and Veterans
To Avert a Serious Threat the Health or Safety
To Workers Compensation
To Resolve or Prevent Public Health Risks
In You Are an Inmate
In Lawsuits and Disputes
For Health Oversight Activities

- You have the right to inspect and copy medical information that may be used to make decisions about your care.
- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the Free Clinic of Simi Valley; is not part of the information which you would be permitted to inspect id copy; or is accurate and complete.
- You have the right to request a list of the disclosures we made of medical information about you other that our own uses for treatment, payment and health care operations, as those functions are described above.
- You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.
  We are not required to agree to your request. If we do agree, additional information may be needed to provide you emergency treatment.
- You have the right to request that we communicate with you about medical matters in a certain way or at certain location.
- You have the right to a paper copy of this notice.

We reserve the right to change this notice. Each time Free Clinic of Simi Valley services are initiated, we will offer you a copy of the current notice in effect. If you believe your privacy rights have been violated, you may file a complaint with the Free Clinic of Simi Valley or with the: Secretary of the Department of Health and Human Services. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission.

I have read this notice and have received a full copy of the Free Clinic of Simi Valley “Notice of Privacy Practices” which more fully explains these practices, lists examples and provides phone numbers for contact.

_____ _____
Client/Patient Name Printed Clearly Date of Birth

_____ _____
Client/Patient Signature or Representative Date

Free Clinic of Simi Valley,
2003 Royal Ave.
Simi Valley CA 930675
805.522.3733

FREE CLINIC OF SIMI VALLEY
2003 Royal Ave. Simi Valley, CA
805.522.3733

Notice to Patients

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable

or

to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA) , (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (0)).

Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal law.

Acknowledged:_____ (Patient/Client Name Printed Clearly)

Signature: _____ (Patient/Client or Representative)

Date of Birth: _____ Today's Date: _____

[1] If the free clinic imposes charges based on a patient's ability to pay, this will negate the FTCA coverage of the volunteer(s) for the specific services for which the clinic received payment.

[2] A licensed or certified health care practitioner is an individual required to be licensed, registered, or certified by the State, Commonwealth or territory in which a Free Clinic is located. These individuals include, but are not limited to, physicians, dentists, registered nurses, and others required to be licensed, registered, or certified (e.g., laboratory technicians, social workers, medical assistants, licensed practical nurses, dental hygienists, and nutritionists). The definition will vary dependent upon legal jurisdiction.

[3] Examples of cases in which a free clinic could grant temporary privileges to a LIP in order to meet important patient care needs for a limited period of time include:

1. A current LIP becomes ill or takes a leave of absence, and another LIP is needed to cover patient care until the current LIP returns; or
2. A current LIP does not have the necessary skills to provide needed patient care.

Free Clinic of Simi Valley

COVID-19 SCREENING QUESTIONNAIRE

Have you experienced any of the following symptoms in the past 48 hours?		
Fever or chills	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Shortness of breath or difficulty breathing	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Muscle or body aches	☐ Yes	☐ No
Headache	☐ Yes	☐ No
New loss of taste or smell	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Congestion or runny nose	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	☐ Yes	☐ No
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	☐ Yes	☐ No
Are you currently waiting on the results of a COVID-19 test?	☐ Yes	☐ No

Name: _____ **Date:** _____