



APPLICATION/REGISTRATION FOR SERVICES

Client ID: _____

Birthdate: _____

Client Information

Client Legal Name: _____ Client Preferred Name: _____

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

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Language: English Spanish Other _____ Religious preference: _____

Marital Status: Married Divorced Widowed Single Separated

Race: Alaska Native Asian Black/African-American Native American White
 Pacific Islander or Native Hawaiian Other single race 2 or more races Decline to answer

Ethnicity: Dominican Hispanic or Latino Not Hispanic or Latino Decline to answer

Assigned Gender: Male Female

Gender Identity: Agender Female Male Genderqueer Non-binary Transgender Other
 Don't know Decline to answer

Sexual Orientation: Gay/Homosexual Straight/Heterosexual Bisexual Don't know Other
 Decline to answer

Pronouns: She/Her/Hers He/Him/His They/Them/Theirs Other Decline to answer

Are you homeless: Yes No

How Did You Hear About Us Name/Clinic: _____ Phone: _____

Emergency Contact

Next of kin:

Name: _____ Phone: _____ Relationship to Client: _____

Address: _____ City: _____ State: _____ Zip: _____ Email: _____

Other emergency contact:

Name: _____ Phone: _____ Relationship to Client: _____

Address: _____ City: _____ State: _____ Zip: _____ Email: _____

Insurance Information Do you have Insurance: Yes No

Name of Insurance: _____ Plan: _____

Policy or ID#: _____ Phone #: _____

Policy Holder Name: _____ Phone #: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____ Email: _____

Primary Care Physician Do you have a Primary Care Physician: Yes No

Name/Clinic: _____ Specialty: _____ Phone #: _____

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

Education/Employment

Education Status: Enrolled Not enrolled Education Level: _____

Employment Status: Employed Not employed Employment Information: _____

Military Status: Currently in the U.S. Military: Yes No Prior experience in the U.S. Military: Yes No

Tobacco Use: Yes No

Advanced Directive: I have an Advanced Care Directive I do not have an Advanced Care Directive

Application/Registration for Services (continued)

Acknowledgements

Yes No I have received a copy of Highland Springs Specialty Clinic’s Notice of Privacy Practices

Yes No I have received a copy of Highland Springs Specialty Clinic’s Client Rights & Responsibilities

_____ (initial) *Abuse or Violence*: I acknowledge and understand that Highland Springs Specialty Clinic may have a legal obligation to report or make referrals in instances of abuse of children and elderly or vulnerable adults to appropriate governmental or law enforcement agencies, and, further, that Highland Springs Specialty Clinic may have a legal obligation to report or make referrals in instances of family violence or threatened crimes to appropriate governmental or law enforcement agencies. I further consent to such reports and/or referrals by Valley.

Emergency Medical Care

Yes No I consent to receive first aid and emergency treatment. This would be if I have an accident, injury, illness or other medical emergency. I understand this applies only during treatment at Highland Springs Specialty Clinic.

Consent

Yes No I consent to treatment and testing / assessment at Highland Springs Specialty Clinic and with Telehealth. I understand testing includes, but is not limited to intellectual, cognitive, developmental and functional testing.

Yes No I hereby consent to have Highland Springs Specialty Clinic staff to communicate with me, where appropriate via e-mail and text messages regarding the following aspects of my medical care and treatment (*prescriptions, appointments and billing*). I understand that e-mail and text messages are not a confidential method of communication. I further understand that there is a risk with these means of communication between my treatment team, clinical office staff, my other physicians or nurse practitioners and myself regarding my medical care and treatment that may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail and/or text communications between my physician, clinical office staff, my other physicians or nurse practitioners and myself regarding my medical care and treatment may be printed out and made a part of my medical record.

I understand that in an urgent or emergency situation I should call my provider or go to the Emergency Room and not rely on email.

I understand that if I have a grievance, I have the right to file a complaint with Valley’s Client Advocate 801-263-7135 and/or DHS Licensing 801-538-4242/dhslicensing@utah.gov.

I further consent to, and agree, that any electronic signatures by me are valid and enforceable as if I signed in person.

I certify that I understand the above information and that it is accurate and complete.

Signature of Client or Legal Representative

Date

Printed Name of Legal Representative

Relation to Client

HSSC Staff Signature

Date