COVID-19 Testing Demographics Form

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

Please Write Clearly

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: (month/day/year): ____/____/____

Month / Day / Year

Home Phone Number: (____) ____-____

Cell Phone/Mobile Number: (____) ____-____

Contact Information

Mailing Address: _____

123 Main Street, Apartment 200

City: _____ Zip Code: _____

12345

E-mail Address: _____

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Other ☐ Prefer not to answer

Gender Identity: ☐ Woman/Female ☐ Man/Male ☐ Non-Binary ☐ Transgender Man (Female to Male)
☐ Transgender Woman (Male to Female) ☐ Other ☐ Prefer not to answer

Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Prefer not to answer

Ethnicity:
☐ Not Hispanic or Latino
☐ Mexican
☐ Latin American
☐ Other Hispanic or Latino
☐ South American
☐ Decline to Specify

Race:
☐ Black, African American
☐ Chinese
☐ Filipino
☐ Hispanic or Latino
☐ Indian
☐ Japanese
☐ Korean
☐ Native American
☐ Pacific Islander
☐ Vietnamese
☐ White/European
☐ Other: _____
☐ Decline to Specify

Preferred Language:

☐ English ☐ Spanish ☐ Vietnamese ☐ Other

Emergency Contact Information:

Emergency contact name: _____

Emergency contact phone number: (Mobile/Home) _____

COUNTY OF SANTA CLARA
Health System

[Patient Sticker/Demographics]

CONSENT TO COVID TESTING

The County of Santa Clara is offering this appointment for COVID-19 testing to any resident who believes they need one, regardless of insurance, ability to pay or whether they have symptoms or not. There is no cost to you for testing, and insurance is not required. However, if you have health insurance that covers this service, your insurance may be billed.

I am requesting testing for COVID-19 by the County of Santa Clara Health System.

CONTACT WITH TESTING RESULTS

Positive results will be provided via a phone call.

If results are negative, I agree to be contacted via the email provided regarding my test results. (Note: this will not be an encrypted email so your protected health information may not be secure.) If we do not have an email address on file for you, the test results will be mailed to the address provided.

We understand you would like to receive your results as quickly as possible. If we are unable to reach you by telephone for positive results, we will contact the person you have designated as an emergency contact.

ASSIGNMENT OF INSURANCE/MEDICAL BENEFITS

I irrevocably assign and transfer to the county all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the county of all insurance and health plan benefits payable for this outpatient service, at a rate not to exceed the charges listed in the charge description masters. I agree that the insurer or plan's payment to the county pursuant to this authorization shall discharge its obligations to the extent of such payment. I agree to cooperate with, and take all steps reasonably requested by, the county to perfect, confirm, or validate this assignment

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the ***Notice of Privacy Practices (NPP)*** of County of Santa Clara Health System (CSCHS). Our NPP gives you information about how we may use and disclose your medical or protected health information (PHI). Our NPP is subject to change. If we change our notice, we will post the revised version in our facilities and on our website here: https://www.scvmc.org/patients-and-visitors/services/Documents/Notice%20of%20Privacy%20Practices%20-%20English%20Mar%202019%20final.pdf

I certify that I am the patient, the patient's legal representative, or otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Signature *(patient or legal representative)*: _____

Print Name: _____ Date: _____

If not patient, relationship to patient_____