Community First Health Centers

Improving the quality of life for our community.

Dear Patient (Parent of Patient),

Welcome to Community First Health Centers!

To efficiently serve you at your first visit, we ask that you bring the following items with you:

- All medical insurance cards
- All dental insurance cards (if a new dental patient)
- Driver's license or state ID
- Legal guardianship documents (if applicable)
- Advance directive documents
- Any current medications (including herbal supplements, prescriptions, and over-the-counter medications)

We also recommend that you bring your previous medical record, immunization records, recent lab results, x-ray images, and/or ER visit notes with you. If you are unsure how to obtain these documents yourself, please let the receptionist know that you would like to sign a release of records form. We will work to obtain your medical records from there.

Review, sign, and date the enclosed forms **and** bring them with you to your appointment. If you have questions regarding the enclosed materials, please feel free to call us in advance. Enclosed you will find:

- Consent for Treatment Form
- **New Patient Registration Form and Health History Assessment Form**
- A Patient Rights and Responsibilities and Protected Health Information statement, provided for your review

Please be sure you arrive at our office **20 minutes** prior to your appointment so we can make sure all the necessary paperwork has been completed.

We look forward to helping you achieve your best health. Thank you for choosing our services.

Sincerely,

Community First Health Centers

This institution is an equal opportunity provider.
Partially funded by a Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services Grant
NCQA Recognition for Patient Centered Medical Home

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

Community *First* Health Centers

MORE QUESTIONS ON BACK

UDS Survey

Community First Health Centers is a Federally-Qualified Community Health Center (FQHC). Our mission is to provide high-quality, individualized care for the people of our community. Because we receive government grant money, we are required to attempt to collect the information below. All information is kept strictly confidential and in no way affects the services rendered to you as a patient.

PATIENT NAME **DATE OF BIRTH** / /

ANNUAL FAMILY INCOME $ _____
☐ CHOOSE NOT TO DISCLOSE

FAMILY SIZE ☐1 ☐2 ☐3 ☐4 ☐5 ☐OTHER
Includes the person completing the form (if a legal union is in place), and any dependents
☐ CHOOSE NOT TO DISCLOSE

MARITAL STATUS ☐Divorced ☐Married ☐Partner ☐Single ☐Unknown ☐Widowed ☐Legally separated

EMPLOYMENT STATUS ☐Full time ☐Part time ☐Not employed ☐Self-employed ☐Retired ☐Unknown

MILITARY ☐Active duty ☐Reserves

STUDENT STATUS ☐Full time ☐Part time ☐Not a student

PRIMARY LANGUAGE(s) SPOKEN ☐English ☐Spanish ☐Other _____ ☐Choose not to disclose

PREFERRED LANGUAGE ☐Same as spoken ☐Other (specify) _____

IS AN INTERPRETER NEEDED? ☐Yes ☐No

RACE
☐American Indian or Alaska Native ☐Black or African American ☐White
☐Native Hawaiian ☐Other Pacific Islander ☐Guamian or Chamorro ☐Samoan
☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese
☐Other Asian (specify) _____
☐Choose not to disclose / decline to specify

ETHNICITY
☐Mexican ☐Mexican-American ☐Chicano/a ☐Puerto Rican ☐Cuban
☐Another Hispanic, Latino/a, or Spanish origin (specify) _____
☐Choose not to disclose / decline to specify ☐Not of Hispanic, Latino/a, or Spanish origin

BIRTH SEX ☐Male ☐Female

SEXUAL ORIENTATION ☐Lesbian/Gay ☐Straight ☐Bisexual ☐Other _____
☐Don't know ☐Choose not to disclose

GENDER IDENTITY ☐Male ☐Female ☐Transgender female/woman ☐Transgender male/man
☐Choose not to disclose
☐Other/something else (describe) _____

MORE QUESTIONS ON BACK

AGRICULTURAL WORKER STATUS	☐ Yes ☐ No	**IF YES, PLEASE CHOOSE ONE:**	☐ Seasonal worker ☐ Migrant worker ☐ Dependent of a → ☐ Seasonal or ☐ Migrant worker
HOMELESS STATUS	☐ Yes ☐ No	**IF YES, PLEASE CHOOSE ONE:**	☐ Homeless shelter ☐ Transitional housing ☐ Doubling up ☐ Street ☐ Permanent supportive housing ☐ Unknown ☐ Other ☐ Choose not to disclose
VETERAN STATUS	☐ Yes ☐ No		
ARE YOU A RESIDENT OF PUBLIC HOUSING (excluding Section 8)**?**	☐ Yes ☐ No		

FOR OFFICE USE: ☐ SCANNED IN TO CHART ☐ TRANSLATION PROVIDED

Housing Status Definitions/Descriptions

Shelter: Please choose this option if you are staying at a homeless shelter, domestic violence shelter, or warming center.

Transitional: Transitional housing is normally a small facility where people transition from a shelter and stay temporarily (usually between 6 months and two years). You usually have to pay some rent, help with chores, and/or cook meals.

Doubled Up: Doubling up (or “Couch Surfing”) means that you are staying with a friend, family member, or acquaintance, and the living situation is temporary and unstable.

Street: Choose this option if you are sleeping outside, in a vehicle or camping trailer, in a tent or campground, or other similar situations that are not normally intended for habitation.

Other: “Other” options include staying in a hotel or motel, or other situation not defined.

Permanent Supportive Housing (PSH): This option does not have a time limit, is normally reserved for those with some type of disabling condition and is based on income. PSH clients have their own residence and can receive these supportive services through specialized programs.

Resources:
42 USC 11360: Definitions Text contains those laws in effect on July 1, 2019
From Title 42-THE PUBLIC HEALTH AND WELFARE CHAPTER 119-HOMELESS ASSISTANCE SUBCHAPTER IV-HOUSING ASSISTANCE Part A-General Provisions
HRSA Uniform Data Systems Reporting Instructions for Health Center Data

Please complete ALL sections

Advance Directive

ONLY complete this section for patients 18 years and older.

An Advance Directive is a legal document that tells health care providers your health care wishes if you cannot speak for yourself. It is also important to name a person you trust as your "Patient Advocate" to speak for you if needed. Once you have made your decisions, we will keep a copy in your file. You may change your mind at any time by giving us an updated copy. ***If we do not have a copy of your Advance Directive on file, we will use Emergency Procedures.***

Our staff can give you more information. Your doctor can answer questions about the form, treatment options, and care.
Please answer the following questions:

- **Are you interested in an Advance Directive?** ○ **Yes** ○ **No**
- **Do you already have an Advance Directive in place?** ○ **Yes** ○ **No**
- **Have you designated a Patient Advocate?** ○ **Yes** ○ **No**
  - **If yes, do we have a copy of this document for your medical record?** ○ **Yes** ○ **No**
    - **Name of your Patient Advocate:** _____
    - **Advocate telephone number/contact:** _____

Release of Health Information

Community First Health Centers may release health information (paper, electronic, x-ray, labs, etc.) to:

- other providers, pharmacies, or facilities that treat the patient to facilitate a continuum of care.
- the insured's insurance companies or agencies that Community First Health Centers uses for billing services.
- to companies that assist in improving the quality and efficiency of care at Community First Health Centers.

I consent to Community First Health Centers' retrieval of my prescription history by electronic inquiry.

Initials: _____

If I cannot be reached by my home phone, a representative may give information about my **(check all that apply)**:

○ **Test Results** ○ **Diagnosis** ○ **Care/Treatment** ○ **Billing Statements**

By the following:

○ **My cell phone** **Cell phone number:** _____

○ **Voicemail or e-mail as listed in demographics**

○ **My spouse** **Spouse's name and phone number:** _____

○ **My children** **Name and phone number:** _____

○ **Other parent or guardian** **Name, relationship, phone number:** _____

○ **Do NOT provide information to anyone other than me**

Initials: _____

Financial Agreement

Community First Health Centers will charge fees for the service rendered for your care. These fees may be estimated at times based on anticipated services to be provided but will always be adjusted to the actual fees associated with the exact services that were provided to you. To ensure Community First bills my insurance company correctly, I am responsible for providing Community First with accurate insurance information.

If you have medical insurance, Community First will bill your insurance company the fees referred to above. I acknowledge and understand that I am responsible to know what medical services my insurance company will cover or not. I also understand that I will be responsible to pay for the amount that my insurance company will not cover which includes insurance co-pays and/or deductibles. **If I have no insurance, I understand that the fees charged to me are my responsibility.

If I have been injured at work or in an accident, I am responsible to provide Community First with the necessary Worker's Compensation or Auto Insurance billing information so that Community First can bill the appropriate responsible party.

Initials: _____

○ Scanned into Chart ○ Translation provided

Please complete ALL sections

Notice of Privacy Practices

Community First Health Centers has provided me with their Notice of Privacy Practices document. I understand that this document explains my rights as a patient and how my PMI (pertinent medical information) is managed. I have received a copy of this. I also understand that if I have a question about this or a concern, I should contact the Community First Health Centers' Privacy Officer. **Privacy Officer's Phone: (586) 270-8055** **Initials: _____**

Consent for Treatment & Acknowledgment

Community First Health Centers provides integrated primary medical, behavioral health, dental, and other health care services to meet your needs regardless of age, gender, gender identity, color, race, ethnicity, creed, national origin, religion, disability, sexual orientation, or veteran status. The purpose of that care is:

- To obtain information through a history and examination for diagnosis and developing a plan of care/treatment.
- To treat disease, mental health, injury, and disability by testing, use of procedures, therapies, and medications.
- To aid patients in achieving their maximum potential within their capabilities.
- To accelerate patient's/client's gradual return to health and strength after illness and reduce the length of the functional recovery.

Referrals will be made to other agencies that are appropriate to the needs of the patient. Photographs or video tape necessary to provide treatment or documentation, may be taken.

As part of your integrated care, we use an electronic health record that includes your medical, mental health, dental, and other health information. To give you the best care possible, all your care team may view the complete record. This does not include Behavioral or Mental Health visit documentation, unless checked below.

[ ] I agree to the sharing of Behavioral Health and Alcohol or Drug Substance Use Information, not including visit psychotherapy note documentation, among Community First Health Centers staff for the reasons indicated above under Consent for Treatment. *Behavioral Health visit psychotherapy notes will not be shared without additional, specific written consent. This authorization also pertains to the Federal Regulation 42 CFR Part 2 of the State Statues regarding Mental Health, Alcohol, and Drug Abuse.*

I agree that if a Community First Health Centers (CFHC) staff person is exposed to my blood or other bodily fluids, CFHC may obtain a blood sample and test my blood for hepatitis and HIV. I consent to the confidential disclosure of the test results to the medical provider treating the CFHC staff person, the staff person, and the HR department of CFHC. Positive test results would need to be reported to the local health department. This authorization will be valid and remain in effect from the date of this consent until revoked.

The signature at the bottom of this page, also provides Consent for Treatment. I fully understand that this consent is given in advance of a specific diagnosis or treatment. I am also aware that this consent will remain in effect until revoked in writing. My consent will be carried over to other Community First Health Centers locations should I choose another provider or service within this organization.

My signature indicates that:

- I have read and understand all the information above and on page 1 of this form.
- The demographic, billing, and insurance information I have provided to Community First Health Centers is correct. I know it is my responsibility to provide up to date information at every visit.
- I have been given an opportunity to ask questions regarding my consent. All my questions have been answered.
- I have been given information regarding Patient Centered Medical Home (PCMH). I understand the concept and accept that patient & family participation is crucial in managing health.
- Community First Health Centers will follow State and Federal laws regarding protecting medical and demographic information.

I am requesting treatment and give my consent for treatment for (***select only one***):

○ **Myself** ○ **Patient Name: _____**

Documentation of relationship provided and scanned into chart:

○ **License** ○ **Court Appointed** ○ **Custodial Parent** ○**Legal Guardian** ○ **Other**

Patient or Parent/Guardian Signature | Date | Patient or Parent/Guardian Name PRINTED

○ Scanned into Chart ○ Translation provided

General Dentistry Consent

I, the undersigned, hereby give consent to the following services provided by Community First Health Centers Dental Clinic as recommended by the Dentist and discussed with me prior to the service.

Fillings: Filling treatment and that during treatment the size of the filling(s) may become larger than originally planned which may require a crown. I also understand that there are no other treatment options for fillings and if left untreated there is a possibility of the tooth breaking, decay getting deeper, or the decay spreading to other teeth.

Crowns: I understand that sometimes it is not possible to match the color of teeth exactly with artificial teeth. I further understand that I will be wearing temporary crown(s), which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand that there will be additional charges for remakes due to my delaying of permanent cementation of a crown.

Alternative treatment: It has been explained to me that the only alternative treatment available is a very large filling, known as a core, build up. This treatment option can cause the tooth to fracture due to its size resulting in further treatment such as a root canal or ultimately the loss of the tooth.

Periodontal Treatment: I understand that if I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss and that it can ultimately lead to the loss of my teeth. I understand that there are no alternative treatment options for periodontal disease, and that I am aware that if left untreated this can result in: gum surgery and/or extractions of teeth.

Dentures and Partials: I understand the wearing of dentures/partials is difficult. Sore spots, altered speech, and difficulty in eating are common problems associated with dentures. Immediate placement of dentures after extractions may be painful. Immediate dentures will require multiple relines and/or a new definitive denture to be made while the tissue and bone heals; this is not included in the denture fee. In addition, all types of delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of 30 days or more, I may be responsible for additional charges passed on to me.

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized. I hereby authorize any of the doctors, dental hygienists, or dental assistants to proceed with and perform the dental restorations and treatments as depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am ultimately responsible for payment of any and all of the dental fees.

_____

Patient or legal guardian signature Date

New Patient Registration and Health History Assessment

Demographic Information

Instructions: Please complete all sections. Bring ID & insurance cards with you.

Patient Name: _____

Date of Birth: _____ **Age:** _____

Email Address (for patients 18 years and older): _____@_____

PARENT INFORMATION – COMPLETE FOR MINOR CHILD	
Insured Parent's Name: Relationship to patient: □ Mother □ Father □ Other:	
Address:	**City, State, Zip:**
Phone:	**Alternate Phone:**

PATIENT ADDRESS

Street: _____ **Apt.:** _____ **City:** _____

County: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

If minor child, name of legal guardian: _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____ **Phone:** _____

FINANCIALLY RESPONSIBLE PARTY

Responsible Party: ○Self ○ Spouse ○ Parent ○ Non-Custodial Parent ○ Other Person

Responsible Party Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

INSURANCE INFORMATION

Dental Insurance

Insurance Company Name: _____ **Subscriber Name:** _____

Subscriber Date of Birth: _____ **Group Number:** _____ **Policy Number:** _____

Patient Relationship to the Insured: _____

Primary Medical Insurance

Insurance Company Name: _____ **Subscriber Name:** _____

Subscriber Date of Birth: _____ **Group Number:** _____ **Policy Number:** _____

Patient Relationship to the Insured: _____

Secondary Insurance □ Dental □ Medical

Insurance Company Name: _____ **Subscriber Name:** _____

Subscriber Date of Birth: _____ **Group Number:** _____ **Policy Number:** _____

Patient Relationship to the Insured: _____

New Patient Registration and Health History Assessment

Patient Medical and Dental History – For Minors

Instructions: Please complete all sections.

Patient Name: _____ Preferred Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Relationship to Patient: _____

Physician's Name: _____ Phone Number: _____

Have you had any medical care within the past two years? ○ Yes ○ No
If yes, please describe: _____

Is this the child's first visit to a dentist? ○ Yes ○ No
If not the first visit, what was the date of the last dental visit?

What is the reason for the child's visit? _____

Does the child complain about any tooth pain? ○ Yes ○ No
If yes, please describe: _____

What type of water does the child drink? ○ City Water ○ Well Water ○ Bottled Water ○ Filtered Water

Does the child take fluoride supplements? ○ Yes ○ No

Is fluoride toothpaste used? ○ Yes ○ No

How many times a day are the child's teeth brushed per day? _____ When are the teeth brushed? _____

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ○ Yes ○ No
○ *Active Tuberculosis* ○ *Persistent cough greater than three-week duration* ○ *Cough that produces blood*
If you answered yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

○ Anemia	○ Cerebral Palsy	○ Hearing	○ Latex Allergy	○ Seizures
○ Arthritis	○ Chicken Pox	○ Heart	○ Liver	○ Sickle Cell
○ Asthma	○ Chronic Sinusitis	○ Hepatitis	○ Measles	○ Thyroid
○ Bladder	○ Diabetes	○ HIV +/AIDS	○ Mononucleosis	○ Tobacco/Drug Use
○ Bleeding Disorder	○ Earaches	○ Immunizations	○ Mumps	○ Tuberculosis
○ Bones/Joint	○ Epilepsy	○ Growth Problems	○ Pregnancy (teens)	○ Venereal Disease
○ Cancer	○ Fainting	○ Kidney	○ Rheumatic Fever	○ Other:

New Patient Registration and Health History Assessment

Patient Medical and Dental History – For Minors

Is the child taking any prescription medications or vitamin supplements at this time? ○ Yes ○ No

If yes, please list: _____

Is the child allergic to any medications? (example: penicillin, antibiotics, other drugs) ○ Yes ○ No

If yes, please list: _____

Is the child allergic to anything else, such as certain foods? ○ Yes ○ No

If yes, please list: _____

How would you describe the child's eating habits? _____

Is the child currently being treated for any illnesses? ○ Yes ○ No

If yes, please list: _____

Has the child ever had a serious illness? ○ Yes ○ No

If yes, when: _____ Please describe: _____

Has the child ever been hospitalized? ○ Yes ○ No

Does the child have a history of any other illnesses? ○ Yes ○ No

If yes, please list: _____

Does the child have inherited problems? ○ Yes ○ No

Does the child have any speech difficulties? ○ Yes ○ No

Is the child physically, mentally, or emotionally impaired? ○ Yes ○ No

Does the child experience excessive bleeding when cut? ○ Yes ○ No

Has the child had any problems with dental treatment in the past? ○ Yes ○ No

Has the child ever had dental radiographs (x-rays) exposed? ○ Yes ○ No

Has the child ever suffered any injuries to the mouth, head, or teeth? ○ Yes ○ No

Has the child had any problems with the eruption or shedding of teeth? ○ Yes ○ No

Has the child had any orthodontic treatment? ○ Yes ○ No

Does the child suck his/her thumb, fingers, or pacifier? ○ Yes ○ No

At what age did the child stop breastfeeding? _____

Does the child participate in active recreational activities? ○ Yes ○ No

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Parent/Guardian Signature Date

New Patient Registration and Health History Assessment

Patient History

Instructions: Please complete all sections. Date: _____

PLEASE BRING ALL MEDICATION BOTTLES TO EACH APPOINTMENT

Patient Name: _____ Date of Birth: _____

Does the child have any current medical conditions we should be aware of? _____

_____

_____

Please list your **current prescription medications** you take:

Medication:	Dosage:	Frequency:	Date Started:

Please list any **over the counter medications** you take regularly, including vitamins & herbal supplements:

Medication:	Dosage:	Frequency:	Date Started:

Women: Are you pregnant or think you could be pregnant? ○ Yes ○ No

Women: Do you use prescription birth control? ○ Yes ○ No

Have you ever taken bone loss prevention drugs, *such as Fosamax, Actonel, Boniva, or other similar drugs?* ○ Yes ○ No

Do you have a latex/tape allergy? ○ Yes ○ No

Do you have a metal allergy? ○ Yes ○ No If yes, please list your allergy: _____

Do you have any additional allergies, including food allergies? If so please list here: _____

_____

Please list any previous hospitalizations and surgeries, including dates and hospital information: _____

_____

_____

_____

Have you recently traveled outside of the U.S. (if yes, please provide the countries and dates below): ○ Yes ○ No

_____

Does the child require any special accommodations during the appointment? ○ Yes ○ No

If yes, please describe: _____

_____

_____

Please describe any religious or cultural needs we should be made aware of when caring for the child: _____

_____

_____

How did you hear about us?

Please complete the form below and let us know how you heard about Community First Health Centers!

Name: _____ Date: _____

Which other (if any) Community First Health Centers' programs do you use?

○ Primary Health Care ○ Dental Services ○ Behavioral Health Services

○ Maternal Infant Health Program ○ Homeless Health Care ○ Women, Infants, & Children (WIC)

Was there anyone that referred you to us that we can thank?

○ A Community First Health Centers' employee ○ Friend or Family Member

○ Other Agency (please tell us who): _____ ○ No one (please complete section B)

A. *If you indicated that someone referred you to us, please provide us the following information so that we can thank them!*

Name: _____ Phone Number: _____

Address: _____

B. *If you checked "No One", how did you hear about us?*

○ Community Event ○ Internet/Website ○ Facebook ○ Newspaper

○ Billboard ○ Sign ○ Postcard

○ Other: _____

For Dental Patients Only

Do you currently see a Community First Health Centers Provider for medical services? ○ Yes ○ No

If yes, which provider do you see?

Patient Rights and Responsibilities

For your records

We at Community First Health Centers view health care as a partnership between you and your caregivers. We respect your rights, values, and dignity. We also ask that you recognize the responsibilities that come with being a patient of Community First Health Centers. Please review the expected Community First Health Centers patient rights and responsibilities outlined below.

Patient Rights:

- Safe, high-quality, medical care, without discrimination, that is compassionate and respects personal dignity, values, and beliefs.
- To participate in and make decisions about their care and pain management, including refusal of care to the extent permitted by law. Care providers (doctors, nurses, etc.) will explain the medical consequences of refusing recommended treatment.
- To have illness, treatment, pain, alternatives, and outcomes be explained in an understandable manner, with interpretation services if needed.
- To know the name and role of your care provider (doctor, nurse, etc.).
- To have treatments, communications, and medical records kept private to the extent permitted by law.
- To have access to medical records in a reasonable timeframe, to the extent permitted by law.
- To be informed about transfers of care to another health organization or provider and alternatives to that transfer.
- To receive information about continuing your health care at the end of each visit.
- To know about any policies that may affect your care or treatment.
- To participate in or decline to participate in research and that declining at any time will not compromise your access to care, treatment, or services.
- To private and confidential treatments, communications, and medical records to the extent permitted by law.
- To receive information concerning advance directives (living will, health care power of attorney, or mental health advance directives) and to have your advance directives respected to the extent permitted by law.
- Full information regarding charges for services and counseling on the availability of known financial resources for health care.
- Access to advocacy or protective service agencies and a right to be free from abuse/neglect.
- Forum for having concerns and complaints addressed; and guarantee that sharing concerns and complaints will not compromise access to care, treatment, and services.
    - **If you have a concern regarding the safety or the quality of your care, please feel free to discuss this with your physician or the Practice Manager of the clinic. You may also contact the Chief of Operations at 586-270-8055.**

Patient Responsibilities

- Partner with the Provider/Medical Home Care Team in establishing a collaborative relationship to address patient's personal health and health behavior issues, providing as much information as possible about your health, medical history, and insurance benefits.
- Keep scheduled appointment or cancel within 24 hours, if possible.
- Contact provider first for all medical issues, other than emergencies perceived to be life-threatening or with potential to permanently impair health status.
- Reports changes in condition or symptoms, and keep medical record up to date, including information on all over-the-counter medications and dietary supplements (such as vitamins, herbal supplements, etc.).
- To ask questions if you don't understand medical instructions, to share concerns, or inability to follow your plan of care.
- Identify and work toward personal life goals and establish care management plans, including clearly identified self-managements goals and responsibilities.
- To meet your financial obligations to the facility.
- To act in a manner that is respectful of and safe for other patients, staff, and facility property. To follow facility policies rules and regulations.

Use and Disclosure of Protected Health Information

For Your Records

Our Responsibilities. Your Information. Your Rights.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Community First Health Centers is required by law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices. Community First Health Centers must abide by the terms of the notice currently in effect, but Community First Health Centers reserves the right to change the terms. If there is a change, the new notices will be available upon request and in our offices.

As a patient of Community First Health Centers, information about you may be shared and disclosed to other parties for purposes of treatment, payment, health care operations and quality assurance purposes. This does not include psychotherapy notes. These uses and disclosures include, but are not limited to, information contained in financial records, medical records, including information concerning communicable diseases, such as Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis, laboratory test results, pharmacy and prescription details, medical history, treatment progress and/or any other related information. Instances of how the information may be shared and disclosed are listed below.

- With your insurance company, self-funded or third-party health plan, Medicare, Medicaid, or any other person or entity that may be responsible for paying or processing for payment any portion of your bill for services.
- Any person or entity affiliated with or representing the agency for purposes of administration, billing, and quality and risk management.
- A hospital, nursing home, or other health care facility to which you may be admitted.
- Any assisted living or personal care facility of which you are a resident.
- Any physician or other health professional providing you care.
- Pharmacies and prescriptions you have used in the past, including query of prescription monitoring programs.
- Family members and other caregivers who are part of your home care plan for service.
- Licensing, accrediting bodies, and/or entities which provide regulatory oversight.
- To contact you to provide appointment and/or preventative service reminders, or to provide information about other health related services or activities by text, email, mail or by phone.
- To contact you to raise funds for Community First Health Centers.
- Other health care providers to initiate treatment.
- For product recalls.
- To report adverse reactions to medications.
- Retrieval or sharing of information electronically through a Health Information Exchange system.

Community First Health Centers is also permitted to use or disclose information about you without consent or authorization in the following circumstances:

1. In emergency treatment situations, Community First Health Centers attempts to obtain consent as soon as practical after treatment. This may include when substantial barriers to communicating with you exist and Community First Health Centers determines that the consent is clearly inferred from the circumstances.
2. Where the use or disclosure is required by law.
3. For certain public health activities. These activities involve public health authorities authorized by law to collect or receive information to prevent or control diseases and/or injury.
4. To an authorized government agency or authority if/when Community First Health Centers reasonably believes you are a victim of abuse, neglect, or domestic violence.
5. Health care oversight activities.
6. Certain judicial administrative proceedings. A court order or subpoena signed by a judge or court magistrate.
7. In response to a court order or subpoena received signed by a judge or court magistrate.
8. To coroners, medical examiners, and funeral directors, in certain circumstances.
9. For research, when all requirements under the HIPAA Privacy Rule (164.512(i)) are met. There must also be documentation that a waiver of the patient's consent for use/disclosure of their PHI approval by an Institutional Review or Privacy Board.

10. As necessary, to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat; this includes the target of a threat.
11. For Workers' Compensation purposes.

Community First health Centers is permitted to use or disclose information about you without consent or authorization provided you are informed in advance and given the opportunity to agree to or prohibit or restrict the disclosure in the following circumstances:

1. The use of a directory of individuals served by Community First Health Centers.
2. To a family member, relative, friend, or other identified person who is involved in your care or the payment of your care. The information that will be shared is only information that is relevant to that person's involvement in your care or payment for care. Other uses and disclosures will be made only with your written authorization. That authorization may be revoked, in writing, at any time, except in limited situations.

YOUR RIGHTS

Under certain circumstances, you have the right to:

1. Request restrictions on certain uses and disclosures of information about you. However, Community First Health Centers is not required to agree to the requested restriction.
2. Receive confidential communication of protected health information.
3. Inspect and copy protected health information.
4. Amend protected health information.
5. Receive an accounting of disclosures.
6. Obtain a paper copy of this notice if you had agreed to receive this notice electronically.
7. Choose someone to act for you such as in the case of a designated Medical Durable Power of attorney.
8. File a complaint if you believe your privacy rights have been violated.
9. Request and receive an electronic or paper copy of your medical record within the timeframe set-forth in the HIPPA federal regulation; a reasonable fee may be charged for this service.
10. Be informed promptly if a breach occurs that may have compromised the privacy or security of your health information.

*Protected Health Information (*PHI) is defined as any information that identifies the individual or could be used to identify the individual, which is collected, transmitted, created, received and/or maintained, in any form or medium, by CFHC and regulated under HIPAA regulations and Michigan law. PHI includes information concerning a person that is living or deceased. PHI is any information in the Designated Record Set (DRS) which is subject to HIPAA regulations.

COMPLAINTS

You may file a complaint with Community First Health Centers and/or ~~the Secretary of~~ the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) if you believe ~~that~~ your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint should be filed in writing with Community First Health Centers and should state the specific incident(s) in terms of subject, date, and other relevant matters. A complaint to U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) can be filed in writing by mail, fax, email or via the OCR Complaint Portal.

For further information regarding filing a complaint or concern with Community First Health Centers, please contact: call 586-270-8055.

I have read or have had this Notice read and/or explained to me. I understand this Notice and have had the opportunity to ask questions regarding any matters of concern.

This notice is effective beginning February 14, 2024.

HOURS OF OPERATION

Community First Health Centers hours vary by location and program. To learn more about program and location specific hours, please visit us online at: www.communityfirsthc.org/contact-locations/.Our website is routinely updated with the most current information for each program and location. Please also note, our medical centers and dental clinics also offer extended access including evening and weekend appointments.

AFTER-HOURS CONTACT

If you are experiencing a medical emergency, please call 9-1-1 or visit the nearest Emergency Department.

For patients who are actively under the care of a Community First Health Center medical or dental provider, you have access to our on-call provider. If you have an urgent, non-life-threatening medical or dental need and you would like to speak with one of our on-providers, call our after-hours phone line. Your call will be returned by the Community First Health Centers on-call provider promptly. Please also note, our after-hour system is not for requesting refills or for making, cancelling, or rescheduling appointments.

Medical Centers:

- Algonac: (810) 794-4917
- New Haven: (586) 749-5197
- Port Huron: (810) 488-8000

Dental Clinics:

- New Haven: (586) 749-8002
- Port Huron: (810) 488-8004