



Dear Patient,

Welcome to Community First Health Centers!

To efficiently serve you at your first visit, we ask you to 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 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 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



Community *First* Health Centers

UDS SURVEY

PATIENT NAME:	DATE OF BIRTH:
----------------------	-----------------------

As a community health center, we offer a sliding fee discount program for health care services that is based on household income and family size. If you would like more information, please contact our office prior to or day of your appointment.

I acknowledge that I am aware of CHFC's Sliding Fee Program []

ANNUAL FAMILY INCOME: \$ _____ Providing this information helps us identify those who may benefit from our sliding fee discount program. All information is kept strictly confidential and in no way affects the services rendered to you as a patient.	FAMILY SIZE: Includes the person completing the form, spouse (if legal union is in place), and any dependents. <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> Other (add #)
---	--

MARITAL STATUS			
<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	<input type="checkbox"/> Partner	<input type="checkbox"/> Single
<input type="checkbox"/> Widowed	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Unknown	

EMPLOYMENT STATUS	MILITARY STATUS	STUDENT STATUS
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Unknown	<input type="checkbox"/> Active Duty <input type="checkbox"/> Reserves Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student

AGRICULTURAL WORKER STATUS			
<input type="checkbox"/> Yes	If Yes, Please	<input type="checkbox"/> Seasonal Worker	<input type="checkbox"/> Migrant Worker
<input type="checkbox"/> No	Choose One:	<input type="checkbox"/> Dependent of a → Seasonal Worker	<input type="checkbox"/> Migrant Worker []

HOMELESS STATUS			
<input type="checkbox"/> Yes	If Yes, Please	<input type="checkbox"/> Homeless Shelter	<input type="checkbox"/> Transitional Housing
<input type="checkbox"/> No	Choose One:	<input type="checkbox"/> Permanent Supportive Housing	<input type="checkbox"/> Unknown <input type="checkbox"/> Other

ARE YOU A RESIDENT OF PUBLIC HOUSING? (excluding Section 8) <input type="checkbox"/> Yes <input type="checkbox"/> No

Sign/Date

Housing Status Definitions/Descriptions

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

Transitional Housing: Transitional housing is normally a small facility where people transition from a shelter and stay temporarily (usually between 6 months and 2 years). You usually have to pay some rent, help with chores, and/or cook meals.

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.

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

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.

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

More Questions Next Page



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 Statutes 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



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): _____ @ _____

Is the patient a child? (If no, please skip to PATIENT ADDRESS) Yes No

PARENT INFORMATION – COMPLETE FOR MINOR CHILD

Mother's Name: (Legal parent)	Father's Name: (Legal parent)
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:

PATIENT ADDRESS

Street: _____ Apt.: _____ City: _____

County: _____ State: _____ Zip Code: _____

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

Marital Status: Married Separated Widowed Divorced Single

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

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 History

Instructions: Please complete all sections.

Date: _____

*****PLEASE BRING ALL MEDICATION BOTTLES TO EACH APPOINTMENT*****

Patient Name: _____

Date of Birth: _____

Reason for your appointment with the office: _____

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

When was your last:

Eye exam:		Hepatitis B vaccine:		Colonoscopy:	
Dental exam:		Flu vaccine:		Pap Smear:	
Tetanus shot:		Pneumonia vaccine:		Mammogram:	



Patient Name: _____

Date of Birth: _____

Please indicate which of the following you have currently or have had in the past:

Symptom	Current Symptom	Past/History
General		
Fever	<input type="radio"/>	<input type="radio"/>
Chills	<input type="radio"/>	<input type="radio"/>
Unexplained Weight Loss	<input type="radio"/>	<input type="radio"/>
Unexplained Weight Gain	<input type="radio"/>	<input type="radio"/>
Unexplained Fatigue	<input type="radio"/>	<input type="radio"/>
Unexplained Weakness	<input type="radio"/>	<input type="radio"/>
Skin		
New or change in mole	<input type="radio"/>	<input type="radio"/>
Rash/Itching	<input type="radio"/>	<input type="radio"/>
Wounds	<input type="radio"/>	<input type="radio"/>
Bruising	<input type="radio"/>	<input type="radio"/>
Breast		
Breast Lump	<input type="radio"/>	<input type="radio"/>
Breast Pain	<input type="radio"/>	<input type="radio"/>
Nipple Drainage	<input type="radio"/>	<input type="radio"/>
Ears/Nose/Throat		
Trouble Swallowing	<input type="radio"/>	<input type="radio"/>
Frequent Sore Throat	<input type="radio"/>	<input type="radio"/>
Frequent Hoarseness	<input type="radio"/>	<input type="radio"/>
Frequent Nose Bleeds	<input type="radio"/>	<input type="radio"/>
Changes in Hearing	<input type="radio"/>	<input type="radio"/>
Eyes		
Change in Vision	<input type="radio"/>	<input type="radio"/>
Redness	<input type="radio"/>	<input type="radio"/>
Itching	<input type="radio"/>	<input type="radio"/>
Drainage	<input type="radio"/>	<input type="radio"/>
Allergic/Immune		
Hay Fever	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>
Respiratory		
Cough	<input type="radio"/>	<input type="radio"/>
Congestion	<input type="radio"/>	<input type="radio"/>
Shortness of Breath	<input type="radio"/>	<input type="radio"/>
Bloody Sputum	<input type="radio"/>	<input type="radio"/>
Tuberculosis ♦	<input type="radio"/>	<input type="radio"/>
Asthma ♦	<input type="radio"/>	<input type="radio"/>
Genitourinary		
Nighttime Urination	<input type="radio"/>	<input type="radio"/>
Increased Frequency in Urination	<input type="radio"/>	<input type="radio"/>
Kidney Issues	<input type="radio"/>	<input type="radio"/>
Bladder Issues	<input type="radio"/>	<input type="radio"/>
Burning or Painful Urination	<input type="radio"/>	<input type="radio"/>
Psychiatric		
Anxiety	<input type="radio"/>	<input type="radio"/>
Stress	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>
Sleep Issues	<input type="radio"/>	<input type="radio"/>
Alcohol Abuse ♦	<input type="radio"/>	<input type="radio"/>
Drug Abuse ♦	<input type="radio"/>	<input type="radio"/>

Symptom	Current Symptom	Past/History
Cardiovascular		
Chest Pain ♦	<input type="radio"/>	<input type="radio"/>
Chest Discomfort	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>
Swelling	<input type="radio"/>	<input type="radio"/>
Heart Surgery	<input type="radio"/>	<input type="radio"/>
Heart Disease ♦	<input type="radio"/>	<input type="radio"/>
Heart Attack ♦	<input type="radio"/>	<input type="radio"/>
High Blood Pressure ♦	<input type="radio"/>	<input type="radio"/>
Low Blood Pressure	<input type="radio"/>	<input type="radio"/>
Artificial Heart Valve ♦	<input type="radio"/>	<input type="radio"/>
Pacemaker	<input type="radio"/>	<input type="radio"/>
Stroke ♦	<input type="radio"/>	<input type="radio"/>
Gastrointestinal		
Heartburn	<input type="radio"/>	<input type="radio"/>
Reflux	<input type="radio"/>	<input type="radio"/>
Indigestion	<input type="radio"/>	<input type="radio"/>
Blood in Stool	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>
Musculoskeletal		
Artificial Joints (hip, knee, etc.) ♦	<input type="radio"/>	<input type="radio"/>
Back Pain	<input type="radio"/>	<input type="radio"/>
Neck Pain	<input type="radio"/>	<input type="radio"/>
Stiffness	<input type="radio"/>	<input type="radio"/>
Muscle Pain	<input type="radio"/>	<input type="radio"/>
Joint Pain	<input type="radio"/>	<input type="radio"/>
Sensitivity to Heat	<input type="radio"/>	<input type="radio"/>
Sensitivity to Cold	<input type="radio"/>	<input type="radio"/>
Excessive Sweating	<input type="radio"/>	<input type="radio"/>
Excessive Hunger	<input type="radio"/>	<input type="radio"/>
Excessive Thirst	<input type="radio"/>	<input type="radio"/>
Neurological		
Headaches	<input type="radio"/>	<input type="radio"/>
Memory Loss	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>
Numbness	<input type="radio"/>	<input type="radio"/>
Tingling	<input type="radio"/>	<input type="radio"/>
Frequent Falls	<input type="radio"/>	<input type="radio"/>
Epilepsy/Seizures ♦	<input type="radio"/>	<input type="radio"/>
Other		
Hepatitis A ♦	<input type="radio"/>	<input type="radio"/>
Hepatitis B ♦	<input type="radio"/>	<input type="radio"/>
Hepatitis C ♦	<input type="radio"/>	<input type="radio"/>
AIDS/HIV Positive ♦	<input type="radio"/>	<input type="radio"/>
Diabetes ♦	<input type="radio"/>	<input type="radio"/>
Cancer Treatment ♦	<input type="radio"/>	<input type="radio"/>
Liver Issues ♦	<input type="radio"/>	<input type="radio"/>

♦ = indicated for dental

○ Scanned into Chart ○ Translation provided



Patient Name: _____

Date of Birth: _____

Please indicate if any relatives have had any of the conditions listed below:

Cancer	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent
Diabetes	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent
Heart Disease	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent
Stroke	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent
High Blood Pressure	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent
Depression	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent
Seizures	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent
Alcohol/Drug Abuse	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent
Thyroid Disease	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent
Fractures	<input type="radio"/> None	<input type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Sibling	<input type="radio"/> Grandparent

Do you require any special accommodations during your appointment? Yes No

If yes, please describe: _____

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

New Patient Registration and Health History Assessment

Medications and E-Prescribing Information

Community First Health Centers uses a computerized prescription program that improves accuracy and convenience of prescribing medications. This program allows for the electronic transmission of most of your prescriptions directly to the pharmacy of your choice. To assist us in implementing this program, we need to collect the information indicated below.

Your PRIMARY Pharmacy Name: _____

Pharmacy Address: _____ **City, State, Zip Code:** _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

Patient or Parent/Guardian Signature

Date



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 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.



Use and Disclosure of Protected Health Information

For Your Records

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 HIPAA 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.



Use and Disclosure of Protected Health Information

For Your Records

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-call 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

CONTROLLED SUBSTANCE MEDICATION AGREEMENT

I have been informed that if I am prescribed certain controlled substances, including, but not limited to, narcotic pain medicines, stimulants, benzodiazepine tranquilizers, and barbiturate sedatives, can abuse those substances or may allow abuse by others, and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, as well as their misuse, and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the provider whose prescribing or to continue prescribing a controlled medication to treat my condition.

1. I will inform my provider of any current or past substance abuse as well as all current prescribed medications.
2. I am aware that I will be required to see my provider every 1-3 months for evaluation of my condition and medication usage and I will keep my scheduled appointments in order to receive medication renewals.
3. Any prescribed controlled medications must come from a Community First Health Centers provider. This medication prescription(s) will come from the provider whose signature appears below, or during his or her absence, from the covering provider.
4. I will obtain this medication from the same pharmacy. Should the need arise to change pharmacies, I will inform the office.
5. I will inform the office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
6. I will inform my other health care providers that I am taking a prescribed controlled substance, and of the existence of this Agreement. In the event of an emergency, I will provide this information to emergency department providers.
7. I agree that my prescribing provider has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.
8. I will not allow anyone else to have, use, sell, or otherwise have access to this medication. The sharing of medications with anyone is absolutely forbidden and is against the law.
9. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.
10. I agree not to alter my medication in any way, and I will take my medication whole, and it will not be broken, chewed, crushed, injected, or snorted.
11. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage or medication schedule must be approved by the prescriber.
12. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.
13. I will not use any illegal controlled substances such as cocaine, etc. I will cooperate with unannounced urine or serum toxicology screenings as may be requested. Failure to comply may result in discontinuation of this medication.
14. I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may result in the discontinuation of prescribed controlled medication.
15. I understand that medication(s) may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, a copy of a filed police report or a statement from me explaining the circumstances may be required before additional prescriptions are considered.
16. If the responsible legal authorities have questions concerning my treatment as may occur, for example, if I obtained medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.
17. Refills will not be given over the phone, after office hours, during the weekends, or on holidays.
18. The risks and potential benefits of these therapies have been explained to me, including, but not limited to, psychological addiction, physical dependence, withdrawal, and overdose.
19. I understand that failure to adhere to these policies and/or failure to comply with the provider's treatment plan may result in cessation of therapy with controlled substance prescribing by this provider or referral for further specialty assessment.
20. I will communicate with my provider concerning the character and intensity of my pain, and how well the pain medication is relieving my pain.
21. For women only: I agree that I am not pregnant and that I will inform my doctor if I become pregnant.

* Mixing opioids with benzodiazepines, alcohol, muscle relaxers, or any other drugs that may depress the central nervous system can cause serious health risks including death or disability.

I, the undersigned patient, attest that I have read, fully understand, and agree to all the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Agreement.

Please note: All patients will be notified of this policy only once at the start of their care. It will not be provided again unless updates are made, but will remain the official policy of Community First Health Centers

Patient or Parent/Guardian Signature

Date

Patient or Parent/Guardian Name PRINTED

○ scanned into Chart ○ Translation provided