Community First Health Centers

Improving the quality of life for our community.

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 (if applicable)
- Any current medications (including herbal supplements, prescriptions, and over-the-counter medications)

We also recommend 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 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 that 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

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.

[ ] 1 [ ] 4
[ ] 2 [ ] 5
[ ] 3 [ ] Other (add #)

MARITAL STATUS

[ ] Divorced [ ] Married [ ] Partner [ ] Single

[ ] Widowed [ ] Legally Separated [ ] Unknown

EMPLOYMENT STATUS

[ ] Full Time [ ] Part Time [ ] Retired
[ ] Self Employed [ ] Not Employed [ ] Unknown

MILITARY STATUS

[ ] Active Duty [ ] Reserves
Veteran [ ] Yes [ ] No

STUDENT STATUS

[ ] Full Time [ ] Part Time
[ ] Not a Student

AGRICULTURAL WORKER STATUS

[ ] Yes If Yes, Please [ ] Seasonal Worker [ ] Migrant Worker
[ ] No Choose One: [ ] Dependent of a → Seasonal Worker [ ] Migrant Worker [ ]

HOMELESS STATUS

[ ] Yes **If Yes, Please** [ ] Homeless Shelter [ ] Transitional Housing [ ] Street [ ] Doubling Up
[ ] No **Choose One:** [ ] Permanent Supportive Housing [ ] Unknown [ ] Other

ARE YOU A RESIDENT OF PUBLIC HOUSING? (excluding Section 8) [ ] Yes [ ] No

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.

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 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 dentures and partials often require a considerable number of adjustments. I understand that failure to keep my 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 indicated above and as explained to me. I understand that this is only an estimate and subject to modification 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

Community First Health Centers

Improving the quality of life for our community.

	/ /
Print patient's full name (LAST, FIRST)	Patient's date of birth

We value you as our patient and appreciate your cooperation in following our Missed/No Show Agreement so that we can provide care to you and others in a timely manner. Missing an appointment or canceling without enough notice creates longer wait times for all, because dental clinic treatment time goes unused. The following are our agency's patient expectations and appointment requirements. Please read each section below to acknowledge that you understand the agreement. Each of these requirements **must** be followed, or the appointment may be counted as a missed or no-show appointment and will be subject to our Broken Appointment Policy. An overview of this policy is given in the Compliance section below.

- **Appointment confirmation:** As a courtesy, we will place a call to the phone number we have on file for you to attempt to confirm your appointment. If we are not able to reach you, you **must** call to confirm the appointment on the business day prior to the appointment **by 12:00 noon**. If you do not call to confirm, your appointment will be given away to another patient and will be counted as a **missed appointment**.

- **Timely cancellations:** If you need to cancel or reschedule your appointment, we require at least 24 hours' notice. A cancellation made less than 24 hours before the scheduled time is considered a **missed appointment**.

- **On-time arrivals:** Timely arrival is a **must**. We set aside a specific amount of time so that treatment can be completed. If you are late for your appointment, there may not be sufficient time to complete treatment, and we may be unable to see you. This will be considered a **missed appointment**. If our schedule allows, and if does not negatively impact other patients, we will do what we can to still see you that day.

  PHONE CALL: Because appointment times vary, we ask that you call our office if you are going to be **more than 5 minutes late**. At that time, a representative from the dental team will let you know if you can still be seen, or if your visit will need to be rescheduled.

- ****REMINDER**: Repeated **missed/no show appointments** caused by late arrival can result in your being placed on Same Day Status.***

- **Compliance** (BROKEN APPOINTMENT POLICY)**:** Patients are allowed **two** missed/no show appointments in any 12-month period. If a **third** broken appointment occurs, you will not be scheduled for any future appointments, and any appointments that are already made will be canceled.

Many patients use our services here at the Community First Health Centers Dental Clinic. Your help in keeping your appointments enables us to provide better and more timely care for all of our patients.

Signature of patient, or signature of a parent or guardian if the patient is under 18 years of age	Print name	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): _____@_____

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:** _____

COMMUNICATION PREFERENCE

Confirmation of appointment type: □ Calls □ Text □ Calls and Text

Time of day for confirmation: □ Morning □ Afternoon □ Evening

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 ☐ I have secondary insurance. If you check this box, please give the information to the receptionist.

New Patient Registration and Health History Assessment

Patient Dental History

Instructions: Please complete all sections. **Date:** _____

Patient Name: _____ **Date of Birth:** _____

Date of last dental visit: _____ **Date of last dental cleaning:** _____

How often do you brush: _____/○daily ○weekly ○never

How often do you floss: _____/○daily ○weekly ○never

Last full set of x-rays: _____ **Reason for your visit today:** _____

Do you have any dental problems now? ○Yes ○No

If yes, please describe: _____

_____

_____

Have you ever been told to take a pre-medication (antibiotic) prior to your dental appointments? ○ Yes ○ No

Do you have pain in your mouth? ○ Yes ○ No

If yes, please describe:

_____

_____

_____

Have you ever experienced:

Clicking of popping of the jaw? ○ Yes ○ No

Pain (joint, ear, side of face)? ○ Yes ○ No

Nervousness before a dental appt.? ○ Yes ○ No

Do you:

Get cold sores, blisters, or lesions? ○ Yes ○ No

Have tired jaws, especially in the morning? ○ Yes ○ No

Smoke or chew tobacco? ○ Yes ○ No

Wear dentures or partials? ○ Yes ○ No

What year were they made? _____

Have you ever had:

Orthodontic treatment? ○ Yes ○ No

Oral Surgery? ○ Yes ○ No

Gum Treatment? ○ Yes ○ No

Bite Plate or Mouth Guard? ○ Yes ○ No

Is there anything else about having dental treatment you would like us to know? ○ Yes ○ No

If yes, please describe: _____

_____

_____

_____

_____

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: _____

Do you 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

_____

Patient Name: _____

Date of Birth: _____

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

Current Symptom	Yes	No	Current Symptom	Yes	No
Gastrointestinal			**Cardiovascular**		
Heartburn	○	○	Chest pain	○	○
Reflux	○	○	Heart Surgery	○	○
Neurological			Heart Disease	○	○
Headaches	○	○	Heart Attack	○	○
Memory Loss	○	○	High Blood Pressure	○	○
Epilepsy/Seizures	○	○	Low Blood Pressure	○	○
Respiratory			Artificial Heart Valve	○	○
Tuberculosis	○	○	Pacemaker	○	○
Asthma	○	○	Stroke	○	○
Genitourinary			**Musculoskeletal**		
Kidney Issues	○	○	Artificial Joints (hip, knee, etc.)	○	○
Psychiatric			**Other**		
Anxiety	○	○	Hepatitis A	○	○
Irritability	○	○	Hepatitis B	○	○
Depression	○	○	Hepatitis C	○	○
Sleep Issues	○	○	AIDS/HIV Positive	○	○
Alcohol Abuse	○	○	Cancer Treatment	○	○
Drug Abuse	○	○	Liver Issues	○	○
			Diabetes	○	○
Do you smoke?	○	○	**If Diabetes question is YES, answer the questions below:**		
If yes, what year did you start?			What is your A1C goal?		
Are you ready to quit or thinking about quitting?	○	○	What is your current A1C value?		

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**

○ Scanned into Chart ○ Translation provided

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.
- Report 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.

Community First Health Centers

Improving the quality of life for our community.

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:_____

_____

Patient or Parent/Guardian Signature Date Patient or Parent/Guardian Printed

○Scanned into Chart ○Translation provided

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