Dear Patient,

Welcome to Community First Health Centers,

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

- All Medical insurance cards
- Driver’s license or state ID
- Legal guardianship documentation (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 and Health History Assessment Form
- A Patient Rights and Responsibilities and Protected Health Information statement are provided for your review

Please be sure that you arrive at our office 20 minutes prior to your appointment so that 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 is a Federally Qualified Community Health Center. Our mission is to provide high quality and individualized care to 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 services rendered to you as a patient.

Patient Name: ____________________________________________  Date of Birth: ________________

**Annual Household Income:** ____________________________

**Number of Dependents:** ____________________________
(Includes all members of the household, including the person that this form is being completed for)

**Housing Status:**
- ○ Not Homeless
- ○ Transitional Housing
- ○ Homeless Shelter
- ○ Other
- ○ Doubling Up
- ○ Street
- ○ Permanent Supportive Housing
- ○ Choose not to disclose

*See the back of this form for definitions/descriptions*

**Race:**
- ○ Asian
- ○ White
- ○ Native Hawaiian
- ○ Other Pacific Islander
- ○ American Indian or Alaska Native
- ○ Black or African American
- ○ Choose not to disclose

**Employment Status:**
- ○ Full-Time
- ○ Part-Time
- ○ Unemployed
- ○ Disabled
- ○ Choose not to disclose

**Ethnicity:**
- ○ Hispanic/Latino
- ○ Not Hispanic/Latino
- ○ Choose not to disclose

**Full-Time Student:**
- ○ Yes
- ○ No
- ○ Choose not to disclose

**Veteran Status:**
- ○ Yes
- ○ No
- ○ Choose not to disclose

**Language(s) Spoken:**
- ○ English
- ○ Spanish
- ○ Other: __________________________ (please list)
- ○ Check if Interpreter Needed

**Preferred language to communicate:**
- ○ Same as Spoken
- ○ Other: __________________________
- ○ Choose not to disclose

**Agricultural Status:**
- ○ Yes
- ○ No

*If yes choose one:*
- ○ Seasonal Worker
- ○ Migrant Worker
- ○ Dependent of a Seasonal/Migrant Worker
- ○ Choose not to disclose

**Gender Identity**
- ○ Male
- ○ Female
- ○ Other
- ○ Transgender Female (Male-to-Female)
- ○ Transgender Male (Female-to-Male)
- ○ Choose not to disclose

**Sexual Orientation**
- ○ Straight
- ○ Gay
- ○ Lesbian
- ○ Something Else
- ○ Choose not to disclose
- ○ Don’t Know
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 WELFARECHAPTER 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 Directives**

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 Advance Directives?  ○ Yes  ○ No
- Do you already have an Advance Directive in place?  ○ Yes  ○ No
- Have you designated a Patient Advocate?  ○ Yes  ○ No
  - Do we have a copy of this document for your medical record?  *  ○ Yes  ○ No
    - Name of your Pt. Advocate ____________________________
    - Advocate Telephone #/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 Rx or prescription history by electroninquiry. 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 #: ____________________________
- Voice mail or e-mail as listed in demographics
- My spouse  Spouse’s name and phone ____________________________
- My children  Name & phone ____________________________
- Other parent or guardian  Name, relationship, & phone ____________________________
- Do NOT provide information to anyone other than me ____________________________

**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. 

__________ (initial)
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

Consent for Treatment

(Initial)

Community First Health Centers provides integrated primary medical, behavioral health, dental care, 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. In order to give you the best care possible, all of your care team may view the complete record. This authorization also pertains to the Federal Regulation 42 CFR Part 2 of the State Statutes in regard to Mental Health, Alcohol, and Drug Abuse.

*The signature below at the bottom of this page 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.

Acknowledgment

My signature indicates that: I have read and understand all of 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 & Federal laws in regards to protecting medical and demographic information.

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

○ Myself
○ Patient Name

Documentation of Relationship provided & 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

Rev. 8.15.2019
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 Partialis:** I understand the wearing of dentures/partialis 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 amount 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’m ultimately responsible for payment of any and all 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: ________________________________ ○ Male ○ Female

Date of Birth: ___________________________ Age: _________

Email Address (for patients 18 years and older): __________________________________________________________

PATIENT ADDRESS

Street: ________________________________ Apt. _________ City: ________________

County: ___________________________ State: ________________ Zip Code: ____________

Cell: ___________________________ Home: ___________________________ Work: ___________________________

Marital Status: ○ Married ○ Separated ○ Widowed ○ Divorced ○ Single

If minor child, name of legal guardian: ________________________________ Lives With: ○ Parent ○ 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: ___________________________

Date of Birth: ____________ Group Number: ____________ Policy Number: ____________

Patient Relationship to Insured: ___________________________

Primary Medical Insurance

Insurance Company Name: ___________________________ Subscriber Name: ___________________________

Date of Birth: ____________ Group Number: ____________ Policy Number: ____________

Patient Relationship to Insured: ___________________________

Secondary Insurance ○ Dental ○ Medical

Insurance Company Name: ___________________________ Subscriber Name: ___________________________

Date of Birth: ____________ Group Number: ____________ Policy Number: ____________

Patient Relationship to Insured: ___________________________
New Patient Registration and Health History Assessment

Patient Dental History

Instructions: Please complete all sections.

Patient Name: _____________________________ Date: ___________ Date of Birth: _______________

Date of last Dental Visit: ___________________________ 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

Describe: _____________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

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

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

Have you ever experienced:

Clicking or popping of the jaw? ......................... ○ Yes ○ No

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

Nervousness before a dental appointment?.......... ○ Yes ○ No

Have you ever had:

Orthodontic Treatment? ............................. ○ Yes ○ No

Oral Surgery? ........................................ ...... ○ Yes ○ No

Gum Treatment? ....................................... ○ Yes ○ No

Bite Plate or Mouth Guard? ........................... ○ Yes ○ No

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 where they made: ________________

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

If yes, please describe: __________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

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Rev. 8.15.2019
New Patient Registration and Health History Assessment

Instructions: Please complete all sections.

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

Patient Name: ___________________________ Date: ___________ Date of Birth: ___________

Do you have any current medical conditions you want us to be aware of?

_______________________________________________________________________________________

_______________________________________________________________________________________

Please list any current **prescription** medications that you take:

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Dosage:</th>
<th>Frequency:</th>
<th>Date Started:</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Dosage:</th>
<th>Frequency:</th>
<th>Date Started:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

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

Women: Do you use birth control prescriptions? ○ 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

Please list any additional allergies you may have:

_______________________________________________________________________________________

_______________________________________________________________________________________

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

_______________________________________________________________________________________

_______________________________________________________________________________________

Have you recently traveled outside of the US (if yes, please list countries and dates below)? ○ Yes ○ No

_______________________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Current Symptom(s):</th>
<th>YES:</th>
<th>NO:</th>
<th>Current Symptom(s):</th>
<th>YES:</th>
<th>NO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td>Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heartburn</td>
<td>●</td>
<td>●</td>
<td>Chest Pain</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Reflux</td>
<td>●</td>
<td>●</td>
<td>Heart Surgery</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td>Heart Disease</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Headaches</td>
<td>●</td>
<td>●</td>
<td>Heart Attack</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Memory Loss</td>
<td>●</td>
<td>●</td>
<td>High Blood Pressure</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td>●</td>
<td>●</td>
<td>Low Blood Pressure</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td>Artificial Heart Valve</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>●</td>
<td>●</td>
<td>Pacemaker</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Asthma</td>
<td>●</td>
<td>●</td>
<td>Stroke</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Kidney Issues</td>
<td>●</td>
<td>●</td>
<td>Artificial Joints (Hip, Knee, Etc.)</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>●</td>
<td>●</td>
<td>Hepatitis A</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Irritability</td>
<td>●</td>
<td>●</td>
<td>Hepatitis B</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Depression</td>
<td>●</td>
<td>●</td>
<td>Hepatitis C</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Sleep Issues</td>
<td>●</td>
<td>●</td>
<td>AIDS/HIV Positive</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>●</td>
<td>●</td>
<td>Cancer Treatment</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>●</td>
<td>●</td>
<td>Liver Issues</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you smoke? ●   ●
If above Diabetes question is answered YES, please answer below questions.

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 value? ●

---

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: __________________

Pharmacy Phone: ____________________________ Pharmacy Fax: __________________

Patient or Parent/Guardian Signature ____________________________ Date __________

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Rev. 8.15.2019
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 Counseling
- ○ Maternal Infant Health Program
- ○ Homeless Health Care
- ○ Women, Infants, and Children (WIC)

Are you interested in learning more about any other Community First Health Centers Services?

- ○ Primary Health Care
- ○ Dental Services
- ○ Behavioral Health Counseling
- ○ Maternal Infant Health Program
- ○ Homeless Health Care
- ○ Women, Infants, and Children (WIC)

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

- ○ Other Community First Health Centers’ Employee
- ○ Friend/Family Member
- ○ Other Agency (Please list who): __________________________
- ○ No one (Please complete Section B)

A. If you indicated that someone referred you to us, please provide 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 (Details): __________________________

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 as 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 polices that may affect your care or treatment.
- To participate in or decline to participate in research and that declining at anytime 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 advanced directives (living will, health care power or 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 586-749-5197.

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 appointments 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).
- 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-management 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.
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, Community First Health Centers will provide you with a written, revised notice as soon as practicable by mail or hand delivery.

As a patient of Community First Health Centers, information about you must be used and disclosed to other parties for purposes of treatment, payment, and health care operations. These uses and disclosures include, but are not limited to, a release of information contained in financial records and/or medical records, including information concerning communicable diseases such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records and/or laboratory test results, pharmacy and prescriptions, medical history, treatment progress and/or any other related information, to:

➢ 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 any portion of your bill for services;
➢ Any person or entity affiliated with or representing for purposes of administration, billing, and quality and risk management;
➢ Any 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 providing you care;
➢ Pharmacies and prescriptions, you have used in the past;
➢ Family members and other caregivers who are part of your home care plan for service;
➢ Licensing and accrediting bodies, including the information contained in the OASIS Data Set to the state agency acting as a representative of the Medicare/Medicaid program;
➢ Contact you to provide appointment reminders or information about other health activities we provide;
➢ Contact you to raise funds for Community First Health Centers
➢ Other health care providers to initiate treatment.

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

1. In emergency treatment situations, if Community First Health Centers attempts to obtain consent as soon as practicable after treatment;
2. Where substantial barriers to communicating with you exist and Community First Health Centers determines that the consent is clearly inferred from the circumstances;
3. Where Community First Health Centers is required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;
5. For certain public health activities;
6. Where Community First Health Centers reasonably believes, you are a victim of abuse, neglect, or domestic violence to a government authority authorized to receive abuse, neglect or domestic violence;
7. Health care oversight activities;
8. Certain judicial administrative proceedings;
9. Certain law enforcement purposes;
10. To coroners, medical examiners and funeral directors, in certain circumstances;
11. For organ, eye or tissue donation purposes;
12. For certain research purposes;
13. To avert a serious threat to health and safety;
Community First Health Centers is permitted to use or disclose information about you without consent or authorization in the following circumstances, Cont’d;

14. For specialized government functions, including military and veterans’ activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situations;

15. 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, the information relevant to such 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

You have the right, subject to certain conditions, 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.

COMPLAINTS

You may complain to Community First Health Centers and the Secretary of the U.S. Department of Health and Human Services 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 incidents(s) in terms of subject, date, and other relevant matters. A complaint to the Secretary must comply with the standards set out in 45 CFR § 160.306.

For further information regarding filing a complaint or concern with Community First Health Centers, please contact:

Renee Mardis, Chief Operating Officer @ 586-270-8055 ext. 249

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

This Notice is effective beginning March 2016.