Creek Valley Health Clinic

We are committed to provide 100% access to quality, safe, professional health services for all citizens of our community and surrounding area without regard to race, religion, age, gender, or ability to pay. Our goal is improved physical and emotional wellness for all.

PATIENT INFORMATION

PATIENT NAME : (Last)	(First)	(Middle)
ADDRESS: P.O. Box	Street Address	
EMAIL ADDRESS:		
CITY:	**STATE:**	**ZIP:**
HOME PHONE: ( )	**BIRTHDATE:**	**AGE:**
SS#	☐ **SINGLE** ☐ **MARRIED** ☐ **OTHER**	

PAYMENT RESPONSIBILITY

IS THE PATIENT COVERED BY HEALTH INSURANCE?	☐ YES	☐ NO	☐ NOT SURE
IF THE PATIENT IS NOT COVERED BY ANY INSURANCES OR HEALTHCARE PLAN , THE RESPONSIBLE PERSON ACCEPTS RESPONSIBILITY FOR PAYMENT OF THIS ACCOUNT. PLEASE DISCUSS ARRANGEMENTS OR DISCOUNT ELIGIBILITY WITH CREEK VALLEY HEALTH CLINIC STAFF. **PLEASE DO NOT ALLOW LACK OF INSURANCES OR FUNDS TO ADVERSELY EFFECT THE HEALTH OF THE PATIENT.**			
NAME AND ADDRESS OF RESPONSIBLE PERSON OR POLICY HOLDER:			
RELATIONSHIP TO PATIENT : ☐ SELF	☐ SPOUSE	☐ PARENT	☐ OTHER: _____
BIRTHDATE:	**ID#**	**GROUP#**	
INSURANCE COMPANY :			
IS PATIENT COVERED BY AN ADDITIONAL INSURANCE COMPANY ?	☐ YES	☐ NO	☐ NOT SURE
NAME OF POLICY HOLDER :		**BIRTHDATE:**	
INSURANCE COMPANY :	**ID#**	**GROUP#**	

EMERGENCY CONTACT

NAME : (LAST)	(FIRST)	(MIDDLE)
HOME PHONE : ( )	**WORK PHONE :**( )	

RELATIONSHIP TO PATIENT: _____

PLEASE CONTINUE THIS FORM ON THE BACK

PATIENT DEMOGRAPHICS (REQUIRED)

These questions are for grant funding measures ONLY and will not affect your service, treatment, or plan of care in any way.

SEXUAL ORIENTATION: ☐ LESBIAN/GAY/HOMOSEXUAL ☐ STRAIGHT/HETEROSEXUAL ☐ BISEXUAL ☐ DON'T KNOW

☐ CHOOSE NOT TO DISCLOSE ☐ OTHER, PLEASE DESCRIBE _____

BIRTH SEX: ☐ M ☐ F

PREFERRED PRONOUNS: ☐ HE/HIS/HIM ☐ SHE/HER/HERS ☐ THEY/THEM/THEIRS ☐ OTHER: _____

GENDER IDENTITY: ☐ MALE ☐ FEMALE ☐ FEMALE-TO-MALE (FTM)/TRANSGENDER MALE/TRANS MAN ☐ MALE-TO-FEMALE/TRANSGENDER FEMALE/TRANS WOMAN ☐ GENDERQUEER ☐ PANSEXUAL ☐ TRANSGENDER

☐ CHOOSE NOT TO DISCLOSE ☐ OTHER OR ADDITIONAL CATEGORY, PLEASE SPECIFY: _____

ARE YOU A VETERAN? ☐ YES ☐ NO **ARE YOU AN AGRICULTURE WORKER?** ☐ YES ☐ NO

HOUSING STATUS: IN THE PAST TWO MONTHS, HAVE YOU BEEN LIVING IN STABLE HOUSING THAT YOU OWN, RENT, OR STAY IN AS PART OF A HOUSEHOLD? ☐ YES ☐ NO

ARE YOU WORRIED OR CONCERNED THAT IN THE NEXT TWO MONTHS YOU MAY **NOT** HAVE STABLE HOUSING THAT YOU OWN, RENT, OR STAY IN AS PART OF A HOUSEHOLD? ☐ YES ☐ NO

PATIENT ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC

PATIENT RACE (CHECK ALL THAT APPLY): ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ DECLINE TO SPECIFY

WOULD THE PATIENT PREFER HEALTHCARE SERVICES IN ANOTHER LANGUAGE?: ☐ YES ☐ NO

IF YES, PLEASE SPECIFY THE PREFERRED LANGUAGE: _____

NAME OF PREFERRED PHARMACY

FIRST CHOICE: _____ **SECOND CHOICE:** _____

HEALTH LITERACY

HOW OFTEN DO YOU NEED TO HAVE SOMEONE HELP YOU READ INSTRUCTIONS, PAMPHLETS, OR WRITTEN MATERIAL FROM YOUR DOCTOR OR PHARMACY?

____ NEVER ____ SOMETIMES ____ RARELY ____ OFTEN ____ ALWAYS

DO YOU HAVE DIFFICULTY: ____ HEARING ____SEEING ____WITH ENGLISH ____OTHER _____

PATIENT OR GUARDIAN (if patient is under age of 18)

PLEASE SIGN HERE THAT ABOVE INFORMATION IS CORRECT:

X_____**DATE:**_____

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20 S. Colvin St. PO Box 418 Colorado City, AZ 86021
Phone: 435.900.1104 Fax 435.900.1145

NEW PATIENT MEDICAL HISTORY

Patient Name: _____ DOB: _____ Birth Sex: M / F

Please provide as much detail as you're able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Previous Primary Care Provider Name: _____ Phone: _____

Address: _____ Fax: _____

What is the reason for your visit today?

_____

Medications – *List any medications you are taking, with dose and how often*

Medication Name	Dose	How often?	Refilled Needed? Y/N

List any vitamins, supplements, and over the counter medicines

1.	**4.**
2.	**5.**
3.	**6.**

MEDICAL HISTORY

Do you have, or have you had, any of the following? If yes, please check the box:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Depression/Emotional Concerns
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Drug/Alcohol Dependency
- ☐ Epilepsy/Seizures
- ☐ Sinus Problems
- ☐ Problems
- ☐ Other (please specify):

- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Immune Disorders
- ☐ Intestinal Problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Skin Disease
- ☐ Stroke Heart
- ☐ Stomach Ulcers

_____

Allergies – *List any allergies and intolerances to medications, food, or the environment*

☐ No Known Allergies

Allergy	Reaction

PLEASE CONTINUE FORM ON BACK

Surgeries and/or Hospitalizations – ***Have you had any surgeries or have been hospitalized? (provide dates/reasons)***

Date	Reason	Date	Reason

Have you had any reactions to anesthesia? ☐ Yes ☐ No If yes, explain: _____

Family History – ***Check all conditions that apply for each family member***

	Alive	Deceased	Age	Hypertension	Heart Disease	Diabetes (1 or 2)	Cancer (list type)
Father							
Mother							
Brothers							
Sisters							
Paternal Grandfather							
Paternal Grandmother							
Maternal Grandfather							
Maternal Grandmother							

Please list any other major medical diagnoses by family members

_____

Alcohol, Tobacco, and Substance Use

Do you use, or have a history of smoking or chewing tobacco? ☐ Yes ☐ No If yes, how many per day?

_____

If you've quit, how long has it been? ☐ Less than 1 year ☐ More than 1 year ☐ More than 3 years ☐ Social smoker

Do you use any type of e-cigarettes or electronic cartridges (i.e. vaping)? ☐ Yes ☐ No

Do you currently or have you recently recreational drugs? ☐ Yes ☐ No

Do you use, or have a history of using alcohol? ☐ Yes ☐ No

If yes, how often? _____ times per day _____ times per week _____ times per month

Do you regularly consume caffeine? ☐ Yes ☐ No

If yes, how much do you consume per day? ☐ 1-2 cups ☐ 2-3 cups ☐ 3-4 cups ☐ more than 4 cups

PHQ- Patient Health Questionnaire- Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things: ☐ not at all ☐ several days ☐ more than half the days ☐ nearly every day

Feeling down, depressed, or hopeless: ☐ not at all ☐ several days ☐ more than half the days ☐ nearly every day

Immunizations

☐ Immunization History Unknown ☐ Immunization record brought in today ☐ No Immunizations by choice

Have you lived or travelled outside the U.S. in the last 6 months? ☐ Yes ☐ No

If yes, where? _____

Have you ever had a positive tuberculosis/PPD test? ☐ Yes ☐ No

VITALS TO BE TAKEN BY MEDICAL ASSISTANT

Temp: _____ HR: _____ BP: _____ Weight: _____ Height: _____

Resp: _____ O2 Sat: _____

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Consent for Evaluation and Treatment

Creek Valley Health Clinic (CVHC) is dedicated to providing primary care, dental and mental health services to Utah and Arizona residents. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. CVHC patients may be referred to providers from other health care specialties within the CVHC treatment team; members of the treatment team will share clinical information with each other as is clinically necessary.

Patient may be seen by advance appointment only except in emergencies. Patient shall call in advance if Patient cannot keep his/her appointment.

Information about Patient will NOT be given to anyone outside CVHC, including family and friends, unless Patient (parent or legal guardian, if a minor) gives written permission. Patient may consent to release his/her information if Patient is age 16 or older for behavioral care and 18 or older for primary or dental care. However, we may release Patient's information to others without the Patient's permission if: 1) Patient poses a threat to him/herself or others; 2) Patient is unable to protect him/herself from risk of harm; 3) Patient is in the legal custody of a government agency or facility; 4) there is evidence of child abuse; 5) Patient's clinical records are requested under court order including a subpoena to which Patient does not object promptly; or 6) Patient is referred to a collection agency in order to collect on an overdue account.

There are fees for all services, and Patient should pay on the day Patient is seen. Health insurance policies may cover a portion of the fees but Patient understands that this may not cover every service. Patient shall tell CVHC staff about changes in financial status including insurance.

The professional staff of CVHC will depend on statements made by Patient, Patient's medical history, and other information to evaluate his/her condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

Some services at CVHC may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet or saved in any way.

Health professions are not exact sciences and no guarantees are made concerning the course or effect of treatment proposed by the provider nor outcomes of treatment. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the treatment staff.

Patient agrees to healthcare communication via email, phone call and or text messages. Patient may opt out of text and or email messaging by notifying the front desk staff.

In treating patients, studies including x-rays, laboratory tests, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff.
Patient accepts the risks of medication and other treatment, and understands additional fees may occur that Patient may be responsible for.

I understand, that if I am 16 years of age or older, I may consent for mental health services; if I am 18 years of age or older, I may consent for all other health services; otherwise my parent or legal guardian will need to consent for services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or my child(ren) as set forth above, including any studies or procedures that CVHC professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Patient Name: _____ Date:_____

Patient/Guardian Signature: _____

Witness: _____ Date: _____

HIPAA Privacy Authorization Form

Disclosure of Health Information

Authorization for Use or Disclosure of Protection Health Information as required by the Health Insurance Portability and Accountability Act.

I hereby authorize Creek Valley Health Clinic to disclose my protected health information (PHI), both verbally and written, to:

Name:	Relationship:	Specific limits to access:	Ph#:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

I authorize the above persons to access the following items in my medical record until I revoke my consent in writing to Creek Valley Health Clinic.

This release is for the following type of information:

☐ All Records ☐ Prenatal Records ☐ Medication History ☐ Billing ☐ Condition/Treatment

☐ Medical Records ☐ Laboratory & Diagnostic Imaging Results ☐ Immunizations

☐ Other (please specify) _____

____ I understand that information released may include medical, mental health, and/or drug and alcohol information. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it.

____ I understand that in order to protect the confidentiality of records, I agree to the release of the necessary information and that my permission is limited to the purposes and persons listed above. I understand that I may withdraw/stop this authorization at any time by written request (except for information already disclosed).

____ I understand that once this facility disclosed my health information per this release, it cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.

____ I understand that I may withdraw this consent to release information at any time by notifying the agency in writing. I understand that if I do not identify a date or event, then this consent will expire one year from the last date of service to me at Creek Valley Health Clinic.

____ I have been given a copy of Creek Valley Health Clinic's Notice of Privacy Practices and have had a chance to ask questions about how my information should be used.

_____

Signature (Patient/Legal Representative) Date

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Creek Valley Health Clinic Privacy Notice

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ACCORDING TO HIPAA (The Health Insurance Portability and Accountability Act) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding your Health Record/Information: Each time you visit a hospital, healthcare clinic, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. It may also contain correspondence and other administrative documents. All of this information, often referred to as your health or medical record, provides the following function:

- Information for planning your care and treatment
- A means of communication among many health professionals who contribute to your care
- Legal documentation describing the care you received
- A means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for law enforcement officials for investigations or mandated reporting
- A tool with which we can access and continually work to improve the care we render and the outcomes we achieve

Your Health Information Rights: Although your health record is the physical property of the healthcare practitioner or facility, the information belongs to you. You have a right to the following:

- Inspect and obtain a copy of your health record as provided in R.S. 40:1299.96 [and CFR 1 64.524]
- Amend your health record as provided in 45 CFR 1 64.528
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 1 64.522
- Obtain a paper copy of the notice of information practices upon request
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528

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- Request communications of your health information by alternative means or alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities: This organization is required to do the following:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We will not use or disclose your health information without your consent or authorization except as provided by laws or described in this notice.

Federal Standards for Privacy of Individually Identifiable Health Information will go into effect on or after **April 15, 2003**. We, therefore, reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will make the new version available to you upon request.

For More Information or to Report a Problem: If you have questions and would like additional information, you may contact our compliance officer at 435-900-1104. If you believe your privacy rights have been violated, you can file a complaint with the manager of health information services or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Signature _____

Date _____

Membership Application - HealthShare Discount Program

PATIENT INFORMATION

Patient's Name: _____

Patient's Birth Date: _____

Today's Date: _____

INCOME

This form verifies income for 12 months. Family income includes combined income of husband, wife, and children from the following: salary and wages, earnings from self-employment, social security, retirement and pension income, and other sources of income.

Patient's Total Family Income $_____ [ ] week [ ] month [ ] year

TOTAL FAMILY SIZE _____

Please list the names and date of birth of your spouse and children (ages 26 and under, if any):

Name	Date of Birth	Name	Date of Birth
1.)		8.)	
2.)		9.)	
3.)		10.)	
4.)		11.)	
5.)		12.)	
6.)		13.)	
7.)		List additional Names on the back of the page	

AGREEMENT

By submitting this application, I affirm that the information above is true and complete. I understand that any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal from the HealthShare Discount Program and its benefits.

☐ I decline providing this information and accept full fees for all services.

Patient Signature *or* Guardian Signature if patient is under 18	

CVHC Staff Signature		
Family Size_____	Income_____	Slide (Circle) A B C D F

If Medicaid with no income, use calculation in eCW: Family Size 1, Income $15,000 to assign slide B
If patients decline, use calculation in eCW: Family Size 1, Income $50,000 to assign slide F

Medicaid [ ]

Creek Valley Health Clinic's HealthShare Discount Program

2022 Sliding Fee Discount Program - Schedule of Discounts

% of Poverty	0 - 100%		101 - 138%		139 - 166%		167 - 200%		200%+
Household Size	Income Between		Income Between		Income Between		Income Between		Above
1	0	13,590	13,591	18,754	18,755	22,559	22,560	27,180	27,180
2	0	18,310	18,311	25,268	25,269	30,395	30,396	36,620	36,620
3	0	23,030	23,031	31,781	31,782	38,230	38,231	46,060	46,060
4	0	27,750	27,751	38,295	38,296	46,065	46,066	55,500	55,500
5	0	32,470	32,471	44,809	44,810	53,900	53,901	64,940	64,940
6	0	37,190	37,191	51,322	51,323	61,735	61,736	74,380	74,380
7	0	41,910	41,911	57,836	57,837	69,571	69,572	83,820	83,820
8	0	46,630	46,631	64,349	64,350	77,406	77,407	93,260	93,260
9	0	51,350	51,351	70,863	70,864	85,241	85,242	102,700	102,700
10	0	56,070	56,071	77,377	77,378	93,076	93,077	112,140	112,140
11	0	60,790	60,791	83,890	83,891	100,911	100,912	121,580	121,580
12	0	65,510	65,511	90,404	90,405	108,747	108,748	131,020	131,020
13	0	70,230	70,231	96,917	96,918	116,582	116,583	140,460	140,460
14	0	74,950	74,951	103,431	103,432	124,417	124,418	149,900	149,900
15	0	79,670	79,671	109,945	109,946	132,252	132,253	159,340	159,340
For each additional person, add	4,720		6,514		7,835		9,440		9,441
Full Fee for Medical Office Visit*	$21 (Nominal Fee)* (15)		$57* (40)		$71* (50)		$86* (60)		Patient Pays Full Charges*
Full Fee for Behavioral Health Office Visit*	$14 (Nominal Fee)* (10)		$36* (25)		$50* (35)		$64* (45)		Patient Pays Full Charges*

*** A 30% prompt pay adjustment on office visit will be made if paid at front desk during check-in**

Updated to reflect current Federal Poverty Guidelines issued Monday, January 16, 2022

1. Eligibility for the Sliding Fee Program will be effective for the following 12 months.
2. To qualify for the Sliding Fee Program, a HealthShare Application must be completed.
3. Office visit fees may not cover specialty or elective items such as: medical procedures, wound care, medications, screenings, etc.

Office Visit up-fro	(A) Nominal	B	C	D	(F) Full Amt
w/ 30%	15.00	40.00	50.00	60.00	81.00
Full Fee	21.00	57.00	71.00	86.00	116.00

Your patient service representative can answer any questions on fees and payment for medical services