Creek Valley Health Clinic

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

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

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- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- 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 _____

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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.

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's or Guardian's Signature _____

Witness _____ Date _____

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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
- ☐ Heart Problems
- ☐ Other (please specify):

_____

- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Immune Disorders
- ☐ Intestinal Problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Skin Disease
- ☐ Stroke
- ☐ 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 smoked marijuana? ☐ 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: _____

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 tfds	(Street Address)		
EMAIL ADDRESS:			
CITY:	**STATE:**	**ZIP:**	
HOME PHONE: ( )	**BIRTHDATE:**	**AGE:**	
BIRTH SEX: ☐ M ☐ F	**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: ☐ **SPOUSE** ☐ **PARENT** ☐ **OTHER**

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

PLEASE CONTINUE THIS FORM ON THE BACK

PATIENT DEMOGRAPHICS: (REQUIRED)

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

☐ CHOOSE NOT TO DISCLOSE ☐ OTHER, PLEASE DESCRIBE _____

GENDER IDENTITY: ☐ MALE ☐ FEMALE ☐ FEMALE-TO-MALE (FTM)/TRANSGENDER MALE/TRANS MAN ☐ MALE-TO-FEMALE/TRANSGENDER FEMALE/TRANS WOMAN ☐ GENDERQUEER ☐ CHOOSE NOT TO DISCLOSE ☐ TRANSGENDER ☐ OTHER OR ADDITIONAL CATEGORY, PLEASE SPECIFY _____

ARE YOU A VETERAN? ☐ YES ☐ NO

ARE YOU HOMELESS? ☐ YES ☐ NO IF YES, PLEASE CHOOSE FROM THE FOLLOWING OPTIONS: ☐ UNKNOWN ☐ STREET ☐ DOUBLING UP ☐ TRANSITIONAL HOUSING ☐ HOMELESS SHELTER ☐ OTHER:_____

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:**_____

Membership Application - HealthShare Discount Program

□ *I would like to apply for the HealthShare Discount Program and receive discounts on my medical visits*.

□ *I do not wish to apply for the HealthShare Discount Program <u>because my income is over 200% Federal Poverty Guidelines</u>. I understand that I will be charged the full fees for all medical visits.*

□ *I do not wish to apply for the HealthShare Discount Program for <u>other reasons</u>. I understand that I will be charged the full fees for all medical visits.*

□ *I am on AHCCCS or Utah Medicaid. Patient may skip and sign bottom of this form.*

PATIENT GENERAL INFORMATION

Patient's Name: _____

Patient's Birth Date: _____

Date of Service: _____

Has patient applied for Medicare/Medicaid/KidsCare within the last 3 months? □ Yes □ No

INCOME DEFINITION

This form verifies income for 30 days. After 30 days, patient must provide additional income verification (see below). Household income includes combined income by all household members from the following sources:

- Salaries and Wages from employment
- Earnings from Self-Employment (minus business expenses, excluding depreciation and capital loss carry-over)
- Interest and Dividend Investment Income
- All Investment and Rental Income, excluding depreciation
- Unemployment Benefits
- Workers' Compensation
- Alimony
- Child Support
- Military Allotments
- Social Security and other Government Benefits
- VA Benefits
- Retirement and Pension Income

Patient's Total Household Income $_____

INCOME VERIFICATION

Creek Valley Health Clinic requires one of the following as income verification:

- Pay stub (most current)
- Signed note from current employer itemizing client's income before taxes
- W-2 forms
- Income tax return (most recent filing year)
- 1099 forms
- Social Security/ Veteran's Administration/ Railroad Retirement benefits letter
- Unemployment documentation
- Bank statements

HOUSEHOLD MEMBERS

Household is defined as up to two adult partners and their dependent children up to age 26, similar to who would qualify as a group for medical insurance, or for federal income tax return purposes.

Please list ALL members of the household.

Name	Relationship to Patient	Age	Employed at:	Individuals Estimated Annual Salary
	SELF			

AGREEMENT AND SIGNATURE

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I accepted as a member of the HealthShare Partnership, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal of the HealthShare Discount Program.

Name of Patient or Guardian (Printed)	
Signature of Patient *or* Guardian if patient is under 18	
Physical Address	
Date	

Thank you for completing this application form and for your interest in joining our HealthShare Discount Program. This program is available to all patients, regardless of income or insurance status.

Staff Use Only: This section applies to AHCCCS and Utah Medicaid Patients Only:

Patient has attested family size of ____ members, and income is Less Than / Greater Than $_____

Medical Records Release Form

Patient Name _____ Date of Birth ___/___/___

SSN _____Address: _____City_____

State _____ Zip Code _____ Phone ( )_____

Email_____

Information Requested From

Facility _____

Address _____ City _____

State _____ Zip Code_____

Phone (___)_____Fax (___)_____

Send Information To

Name Creek Valley Health Clinic

Send by ☐ mail ☐ fax

Address 20 S. Colvin St. _____ City Colorado City

State Arizona _____Zip Code 86021

Phone (435) 900-1104 _____Fax (888) 396-5140

I, _____ herby authorize you to release confidential health information about me, by releasing a copy of my medical record (medical history lab/imaging and physicals) or a summary or narrative of my protected health information to Creek Valley Health Clinic.

Patient Signature_____ Date _____