# PEDIATRIC PATIENT CONSENTS AND NOTICE OF PRIVACY PRACTICES

Today's Date:

| Last Name | First Name | Date of Birth (mm/dd/yyyy) |
|---|---|---|
| | | |

## CONSENT TO TREATMENT

By signing below, I agree to receive medical care from La Pine Community Health Center (LCHC). I understand that:

- This consent to treatment will be in effect as long as I am under the care of LCHC.
- I may cancel this consent in writing at any time.

## CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION

Protected health information (PHI) is made up of identifying information and health history such as diagnosis, testing, treatments, etc.

By signing below, I understand and agree that LCHC may use or release my PHI for purposes of:

- Providing treatment;
- Payment;
- Healthcare operations;
- As is reasonably necessary to comply with any court order, subpoena, or any other legal requirement(s) or regulation(s) as long as a separate authorization is not required under HIPAA regulations; or
- As is otherwise permitted under HIPAA regulations.

## NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

LCHC's Notice of Privacy Practices (NPP) gives information about how LCHC may use and release your PHI.

I understand that:

- I have the right to receive a copy of LCHC's NPP.
- I may request a copy at any time.
- The notice may be revised.
- I am entitled to a copy of any revised NPP.

By signing below, I acknowledge the above statement and that I have received or been offered a paper copy of LCHC's NPP.

## EMERGENCY MEDICAL TRANSPORTS FROM LA PINE COMMUNITY HEALTH CENTER

If your medical provider recommends emergency medical transport by ambulance from one of our health center locations to the St. Charles Health Systems emergency department, you have the right to refuse the transport against medical advice. If you choose to be transported according to your medical providers recommendation, your insurance will be billed by the ambulance service provider. If you do not have insurance, the invoice will be billed to you.

I understand that I have the right to refuse emergency medical transport and that I will be asked to sign an AMA (Against Medical Advice) form.

I understand that if I choose to be transported, my insurance (or I) will be billed for the transport.

By signing below, you acknowledge the above statements.

*I hereby acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.*

| Patient (or Legal Guardian) Signature | Date |
|---|---|
| | |

La Pine Community HEALTH CENTER

# PEDIATRIC DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA FORM)

Today's Date:

| Last Name | First Name | Date of Birth (mm/dd/yyyy) |
|---|---|---|
| | | |

**La Pine Community Health Center may leave a voicemail for the following: (check all that apply)**

☐ General info regarding your care ☐ Billing ☐ Behavioral Health ☐ Substance abuse ☐ **Do not** leave voicemails for any reason.

**Use:** ☐ Preferred number only ☐ Any personal number on file

**Phone Number**

**If there is anyone that you would like to give us permission to speak with regarding your healthcare in person or by telephone, please indicate below:**

## HIPAA CONTACT 1

| Last Name | First Name | Relationship | Phone |
|---|---|---|---|
| | | | |

☐ Schedule/cancel appointments ☐ Medical Health ☐ Behavioral Health ☐ Substance Abuse ☐ Discuss **ALL** information
☐ Pick up items from LCHC including medications, hardcopy RX's, correspondence, etc.

## HIPAA CONTACT 2

| Last Name | First Name | Relationship | Phone |
|---|---|---|---|
| | | | |

☐ Schedule/cancel appointments ☐ Medical Health ☐ Behavioral Health ☐ Substance Abuse ☐ Discuss **ALL** information
☐ Pick up items from LCHC including medications, hardcopy RX's, correspondence, etc.

**Please list anyone other than parents/legal guardians, ages 18 and older, who may seek medical care (scheduled visits and walk-in) for the minor patient (stepparents, grandparents, etc.), if any.**

| Last Name | First Name | Relationship | Phone |
|---|---|---|---|
| | | | |
| **Last Name** | **First Name** | **Relationship** | **Phone** |
| | | | |

**Patient (or Legal Guardian) Signature** **Date**

La Pine Community HEALTH CENTER

## PEDIATRIC PATIENT INFORMATION

Today's Date:

**Last Name** | **First Name** | **M.I.** | **Date of Birth (mm/dd/yyyy)** | **SSN**

**Sex at Birth** ☐ Male ☐ Female ☐ Not recorded on birth certificate ☐ Intersex ☐ Choose not to disclose ☐ Unknown

**Legal Sex** ☐ Male ☐ Female ☐ Nonbinary ☐ Unknown ☐ X

**Preferred Pronoun** ☐ He/him/his ☐ She/her/hers ☐ Other: _____ ☐ Decline to answer

**Marital Status** ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Married ☐ Legally Separated ☐ Significant Other ☐ Other

**Street Address** | **City** | **Zip**

**Mailing Address** ☐ Same as above | **City** | **Zip**

**Primary Phone Number** | **Secondary Phone Number** | **Email Address**

## LEGAL GUARDIAN INFORMATION

**Primary Guardian (last name, first name)** | **Date of Birth (mm/dd/yyyy)** | **SSN**

**Street Address** ☐ Same as patient | **City** | **Zip**

**Primary Phone Number** | **Secondary Phone Number** | **Relationship to Patient** | **Sex** ☐ Male ☐ Female

**Secondary Guardian (last name, first name)** | **Date of Birth (mm/dd/yyyy)** | **SSN**

**Street Address** ☐ Same as patient | **City** | **Zip**

**Primary Phone Number** | **Secondary Phone Number** | **Relationship to Patient** | **Sex** ☐ Male ☐ Female

## EMERGENCY CONTACT INFORMATION

**1st Emergency Contact (last name, first name)** | **Relationship to Patient** | **Phone Number**

**2nd Emergency Contact (last name, first name)** | **Relationship to Patient** | **Phone Number**

## ETHNICITY, RACE, AND AGRICULTURAL STATUS

**Ethnicity (check all that apply)** ☐ Non-Hispanic or Latino ☐ Mexican, Mexican American, or Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Multiple or Unknown Granularity of Hispanic, Latino/a or Spanish Origin ☐ Another Hispanic Latino and/or Spanish Origin

**Race (check all that apply)** ☐ Alaskan Native ☐ American Indian ☐ Asian Indian ☐ Black/African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Choose not to disclose ☐ Don't know

LaPine Community HEALTH CENTER

**How did you hear about us?**

☐ TV ☐ Newspaper ☐ Social Media ☐ Friend/Family ☐ Internet ☐ Radio ☐ Another provider

# PEDIATRIC MEDICAL HISTORY

Patient Name: Today's Date:

## FAMILY INFORMATION

**Mother's Name (last name, first name)** ☐ Biological ☐ Step ☐ Adoptive ☐ Foster Lives with child ☐ Yes ☐ No

**Father's Name (last name, first name)** ☐ Biological ☐ Step ☐ Adoptive ☐ Foster Lives with child ☐ Yes ☐ No

**Siblings (at home, first names & ages)**

**Other (name & relationships)**

**Are there any tobacco users/smokers in the home?** ☐ Yes ☐ No **Is anyone in the home a regular user of alcohol/drugs?** ☐ Yes ☐ No

**Are there any guns/firearms in the home?** ☐ Yes ☐ No **Is anyone in the home being hit/hurt or touched in a bad way?** ☐ Yes ☐ No

## BIRTH HISTORY

**Pregnancy was:** ☐ Full term (>37 weeks) ☐ Early ☐ Late **Pregnancy lasted:** weeks (normal is 40)

**Birth Weight:** pounds, ounces **Pregnancy Complications:**

**Tobacco/Alcohol Use While Pregnant?** ☐ Tobacco ☐ Alcohol

**Birth Complications:**

**Hospital Stay Lasted:** ☐ 1-3 days ☐ Prolonged >3 days due to:

**Hearing Screen Passed:** ☐ Yes ☐ No

## SURGERIES/HOSPITALIZATIONS

| Year | Reason for Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## FAMILY HEALTH HISTORY (grandparents, parents, siblings children) ☐ Adopted?

| Problem | Relationship | Please Check One | Age | Type |
|---|---|---|---|---|
| Arthritis | | ☐ Maternal ☐ Paternal | | |
| Cancer | | ☐ Maternal ☐ Paternal | | |
| Depression | | ☐ Maternal ☐ Paternal | | |
| Diabetes | | ☐ Maternal ☐ Paternal | | |
| Heart Disease | | ☐ Maternal ☐ Paternal | | |
| High Blood Pressure | | ☐ Maternal ☐ Paternal | | |
| Kidney Disease | | ☐ Maternal ☐ Paternal | | |
| Stroke | | ☐ Maternal ☐ Paternal | | |
| Other | | ☐ Maternal ☐ Paternal | | |

## IMMUNIZATIONS

Do you believe you/your child is up-to-date on recommended immunizations? ☐ Yes ☐ Not Sure

Do you have an up-to-date copy of your/their immunization record? ☐ Yes ☐ No

## CHRONIC ILLNESSES OR DEVELOPMENTAL CONCERNS

## ALLERGIES (please list)

## CURRENT MEDICATIONS (prescription, over the counter, herbal, inhalers)

# PATIENT AGREEMENT

Patient MRN:

**Your Commitment to Us:**

- I agree to treat all staff and clients of La Pine Community Health Center (LCHC) with dignity and respect.
- I agree to arrive 15 minutes prior to my scheduled appointment time.
- I agree to cancel appointments that I cannot attend at least 24 hours prior to my scheduled appointment time or I will be considered a “No Show”.
- I understand that three (3) “no shows” within a 12-month period could result in losing privileges to schedule future appointments.
- I understand that if I arrive more than ten (10) minutes past my scheduled appointment time, I will need to reschedule.
- I understand that I may request a copy of the Notice of Privacy Practices (HIPAA) and any other patient consent or authorization documents at any time.
- I agree to provide LCHC with any updates to my address, insurance, contact information or any other information that could affect LCHC’s ability to provide care.
- I understand that weapons are not allowed on LCHC property.

## ATTESTATION

**By signing below,** I attest that I have read and understand La Pine Community Health Center’s (LCHC) Patient Agreement and agree to the above statements. I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

| Patient (or Legal Guardian) Signature | Printed Name (if not the patient) | Date |
|---|---|---|
| | | |

La Pine Community HEALTH CENTER

# PEDIATRIC PATIENT COMMUNICATION PREFERENCE FORM

Today's Date:

| Last Name | First Name | Date of Birth (mm/dd/yyyy) |
|---|---|---|
| | | |

## COMMUNICATION METHODS

How would you like us to communicate with you about the following items? Check all that apply.

| | | | |
|---|---|---|---|
| Appointment Reminders | ☐ Phone Call | ☐ Text | |
| Billing | ☐ Phone Call | ☐ Mail | ☐ MyChart |
| Medical | ☐ Phone Call | ☐ Mail | ☐ MyChart |

## MYCHART REGISTRATION

If you would like to sign up for MyChart, our online patient portal, to access the patients electronic health information, please let one of our friendly team members know.

## LANGUAGE PREFERENCES

What is your preferred **spoken** language? _____

What is your preferred **written** language? _____

Do you need an interpreter? ☐ Yes ☐ No If yes, in which language? _____

Please choose the option that best describes your English fluency: ☐ Excellent ☐ Very Good ☐ Good ☐ Not Good

## OTHER

Are you visually impaired? ☐ Yes ☐ No If yes, at what age did this begin? _____

Are you hearing impaired? ☐ Yes ☐ No If yes, at what age did this begin? _____

Is this (are these) a disability? ☐ Yes ☐ No

## ATTESTATION

**By signing below,** I acknowledge that I understand that La Pine Community Health Center may occasionally communicate with me via the email address provided on the Patient Information form for quality improvement efforts, appointment reminders and general information. I understand that no medical information or test results will be communicated via email. I understand that I have the right to refuse email communications by requesting that my email address be removed from my file.

| Patient (or Legal Guardian) Signature | Printed Name (if not the patient) | Date |
|---|---|---|
| | | |

Relationship to Patient

LaPine Community HEALTH CENTER

# FINANCIAL POLICY AND AGREEMENT

Today's Date:

| Last Name | First Name | Date of Birth (mm/dd/yyyy) |
|---|---|---|
| | | |

## PATIENT RESPONSIBILITY

**Payment is required at the time services are rendered unless other arrangements have been made in advance.** This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. As a thank you for paying your balance IN FULL, we offer a 25% discount off the balance due. We cannot discount co-pays. We accept cash, personal checks, debit and credit cards. A service charge will be added for returned checks.

## INSURANCE COVERAGE

**Coverage:** ☐ **Yes** ☐ **No** **Insurance Name:**

After we provide healthcare services to you, we will bill your insurance. We will bill all insurance companies, but we have no control over the dollar amount a non-participating company will pay for your services. Payment has been set by these companies without our input and as a result, you could possibly be left with an account balance higher than expected. You, the patient, have a contract with your insurance company and **we cannot guarantee that your insurance will cover our services**. We suggest that you verify coverage with your insurance company prior to your appointment. Payment for services provided to you is ultimately your responsibility. It is the patient's responsibility to notify the health center of any insurance coverage changes. **Please bring your insurance card to every visit** so that we may ensure that our records are kept current.

## DISCOUNTED FEE PROGRAM (SLIDING FEE SCALE)

LCHC is proud to offer a Discounted Fee Program (sliding fee scale) to all qualifying patients. Upon approval, your visit may be discounted to a nominal fee. To apply, please request an application from an employee or print from our website, complete the application and return with proof of income for every person in your household.

## PAST DUE ACCOUNTS

Patients with an outstanding balance must make arrangements for payment. A payment plan option is available for those who are unable to pay in full at the time of service. On accounts where a payment arrangement has been made, payment is due by the date agreed upon. **Patient balances greater than 90 days old or those failing to honor agreed upon payment terms may be turned over to our collection agency.** Please contact us to apply for our Discounted Fee Program or for assistance with applying for Oregon Health Plan (OHP).

## ATTESTATION

**By signing below,** I attest that I have read and understand La Pine Community Health Center's (LCHC) Financial Policy. I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the agency for costs of collections, including attorney fees. I accept full financial responsibility and hereby assign to LCHC any and all insurance benefits due to me to the full extent of my financial obligation to said provider. I understand that I am responsible to LCHC for charges not covered by this assignment. I agree that payments will not be delayed or withheld because of any insurance coverage and all proceeds of insurance are assigned and/or payable to this office where applicable. In the event of non-payment I will bear the cost of collection and/or court costs and reasonable legal fees, should this be required. I authorize the release of pertinent medical records to my insurance carrier(s). I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

| Patient (or Legal Guardian) Signature | Printed Name (if not the patient) | Date |
|---|---|---|
| | | |

La Pine Community HEALTH CENTER

**Billing Questions and Assistance**

If you need assistance or have questions regarding billing issues or the Financial Policy, please contact the billing office between 8:00 a.m. and 5:00 p.m., Monday through Friday, at 541-536-3435.

# REQUEST FOR RECORDS | HEALTH SCREENINGS

Today's Date:

**Last Name** | **First Name** | **Date of Birth (mm/dd/yyyy)** | **Gender at Birth** ☐ Male ☐ Female

## COLORECTAL CANCER SCREENING

**Date of most recent color cancer screening:** ☐ Never/NA ☐ Decline to answer

**Type of screening completed:** ☐ Stool card (FIT, Cologuard) ☐ Colonoscopy ☐ Sigmoidoscopy

**Screening Location** (name of provider, testing center, etc.) **Phone Number**

## DIABETES SCREENING

**Date of most recent A1C test:** ☐ Never/NA ☐ Decline to answer

**Screening Location** (name of provider, testing center, etc.) **Phone Number**

## FEMALE PATIENTS ONLY

## CERVICAL CANCER SCREENING

**Date of most recent Cervical Cancer Screening (PAP exam):** ☐ Never/NA ☐ Decline to answer

**Screening Location** (name of provider, testing center, etc.) **Phone Number** (if other)
☐ East Cascade Women's Group ☐ St. Charles Women's Health ☐ Other:

**Have you had a Hysterectomy?** ☐ Yes (Date: ) ☐ No

**Procedure Location** (name of provider, testing center, etc.) **Phone Number**

## BREAST CANCER SCREENING

**Date of most recent breast cancer screening (Mammogram):** ☐ Never/NA ☐ Decline to answer

**Screening Location** (name of provider, testing center, etc.) **Phone Number** (if other)
☐ Central Oregon Radiology Associates (CORA) ☐ Other:

## ATTESTATION

**By signing below,** I authorize La Pine Community Health Center to request records related to any of the above screenings as necessary to update my health records.

**Patient (or Legal Guardian) Signature** **Date**

LaPine Community HEALTH CENTER

# PROFESSIONAL DISCLOSURE STATEMENT | BEHAVIORAL HEALTH SERVICES

Behavioral Healthcare is a model of care that focuses on increasing positive health outcomes of those we serve. Your provider may refer you to see someone on our Behavioral Health team during your visit. Your provider will continue to take care of your medical needs and may work with you and the Behavioral Health team on some of the following situations that could be causing challenges in your life:

- Difficulty with life situations
- Stress
- Addressing family dynamics
- Coping with medical diagnoses
- Substance use
- Child behaviors
- Sleep
- Trauma
- Focus on nutrition & movement
- Learning/memory concerns
- All types of mental health issues
- And more

Services **do not include**:

- Court-ordered evaluations or care
- Special evaluations (e.g., custody or psychological)
- Longer term therapy
- Disability determination

## CLIENT INDIVIDUAL RIGHTS

As a patient receiving services from an Oregon licensee or Registered Counselor Intern in the state of Oregon you have the following rights (OARS 309-019-0115):

- **Respect and dignity** – You have the right to be treated kindly and fairly.
- **Choice in services** – You can help choose the services and supports that fit your needs and goals.
- **Involvement in your plan** – You can help make your treatment plan, get a copy, and help update it.
- **Clear information** – You have the right to know what your services are, what they are for, and any risks.
- **Privacy** – Your personal information is private and will only be shared as the law allows.
- **Consent** – Services start only after you agree (except in an emergency).
- **For youth 14 and older** – You can agree to your own care. Your family will be involved near the end if it's safe.
- **See your records** – You can look at your medical records.
- **Say no to research** – You do not have to be in any experiments or research.
- **Right medications** – You will get medicines that match your health needs.

## BILLING

**Billing:** This practice serves all patients regardless of ability to pay. You may be billed for Behavioral Health services depending on your insurance plan. If you receive a bill for these services and need help to pay it, please let us know. We may be able to help.

## ATTESTATION

**By signing below,** I acknowledge that I have reviewed and understand the above information. I understand that by participating in this program, I consent to treatment and understand the nature of the services provided in accordance to OARS 309-019-0115 (f) A-C.

| **Patient or Legal Guardian Signature** | **Printed Name (if not the patient)** | **Date** |
|---|---|---|
| | | |

| Relationship to Patient |
|---|
| |

La Pine Community HEALTH CENTER

**Questions?** If you have questions or concerns about this disclosure or your treatment plan, please discuss with your provider.

# PATIENT DEMOGRAPHIC AND HOUSING SURVEY

Patient Name:

As a Federally Qualified Health Center (FQHC) we are required to report the information requested on this survey. Your cooperation is greatly appreciated, and your answers will be held in the strictest confidence.

## HOUSEHOLD INFORMATION

How many people live in your household? _____

Estimated yearly household income: _____

## HOUSING

Has your housing situation changed dramatically in the past year? ☐ Yes ☐ No

Are you living in a shelter or other transient housing? ☐ Yes ☐ No

**Homelessness** (Please check the box that most closely fits your current situation)**:**

- ☐ Not homeless
- ☐ At risk for homelessness
- ☐ Child at risk for homelessness
- ☐ Not currently homeless, but homeless in the past 12 months
- ☐ Homeless unknown shelter
- ☐ Living in Shelter
- ☐ Permanent supportive housing
- ☐ Single occupancy hotel
- ☐ Street, camp, bridge
- ☐ Transitional housing
- ☐ Veteran at risk for homelessness

**Migrant/Seasonal Status** (Please check the box that most closely fits your current situation)**:**

☐ Migrant ☐ Seasonal ☐ Neither

**Public Housing:**

☐ Yes ☐ No

**Patient Housing Status** (Please check the box that most closely fits your current situation)**:**

- ☐ Choose not to disclose
- ☐ Group home
- ☐ Recovery center
- ☐ Stable/permanent
- ☐ Temporary
- ☐ Unstable
- ☐ Vehicle
- ☐ Other

## AGRICULTURAL STATUS

In the past 24 months, have you or another wage earner in your immediate family:

- Been hired to do farm work including the processing or delivery of agricultural products? ☐ Yes ☐ No
- Earned over ½ of your family income from farm work? ☐ Yes ☐ No

In the past 24 months, have you:

- Moved from this area to another country or state in search of farm work? ☐ Yes ☐ No
- Lived in this area and only worked during the harvest season? ☐ Yes ☐ No

LaPine Community HEALTH CENTER

If you would prefer to opt out of this survey, please check the box below.

☐ Choose Not to Disclose This Information