CHIRICAHUA
COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Permission to
Treat Minor Child in
Parent/Guardian's Absence

Permission To Treat Minor Child in Parent/Guardian's Absence

I, _____ am the legal guardian of _____, a minor child, whose date of birth is _____. I hereby give (check one of the following):

Check ONE

☐ Permission to treat my child, who is at least 14 years of age, and to undergo minor surgical procedures including dental procedures (such as fillings, extractions, crowns, cleaning), veni-punctures, consent to receive immunizations, and injections of medications in my absence. I understand that I will receive communication about my child's treatment plan or recommendations via a written or electronic patient plan to be sent home with him/her or emailed securely via patient portal. This authorization shall remain in effect unless rescinded in writing.

☐ Permission to: _____ (named person) to accompany the above named child and allow this child to be treated and undergo minor surgical procedures including dental procedures (such as fillings, extractions, crowns, cleaning), veni-punctures, consent to receive immunizations, and injections of medications in my absence, **until I revoke permission.**

☐ Permission to: _____ (name person) to accompany the above named child and allow this child to be treated and undergo minor surgical procedures including dental procedures (such as fillings, extractions, crowns, cleaning), veni-punctures, consent to receive immunizations, and injections of medications in my absence, **for the following day(s) only: _____.**

Print Parent or Legal Guardian name: _____

Signed: _____ Date: _____

Two witnesses (CCHCI staff) OR Notary Public

Witnessed by: _____ Date: _____

Witnessed by: _____ Date: _____

Notary

State of Arizona

County of _____

Subscribed and sworn (or affirmed) before me this _____ day of _____ 20_____.

_____ _____

Notary Public My commission Expires:

CHIRICAHUA COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Patient Registration Form

(Please Print Clearly)

Preferred Contact Method: ❑ Phone ❑ Text ❑ Voice Mail **Preferred Language:** ❑ English ❑ Spanish ❑ Other:_____

PATIENT INFORMATION

Patient's Last Name:	First:	Middle Initial:	Date of Birth:	Marital Status:
			/ /	❑ Single ❑ Married ❑ Divorced ❑ Widowed
Prefered Name:				

Primary Phone:	Alternate Phone:	Email Address:
( )	( )	

Veteran:	Birth Gender:	Current Gender:	Preferred Pronoun:	Gender Identity:
❑ Yes ❑ No	❑ Male ❑ Female ❑ Other: _____	❑ Male ❑ Female ❑ Other: _____	❑ He ❑ She ❑ Other: _____	❑ Male ❑ Female ❑ Chose not to disclose ❑ Male-to-Female (MTF)/ Transgender Female ❑ Female-to-Male (FTM)/ Transgender Male ❑ Genderqueer, neither exclusively male nor female ❑ Other, please specify: _____

Sexual Orientation:

❑ Straight (Heterosexual) ❑ Lesbian, Gay (Homosexual) ❑ Bisexual ❑ Don't Know
❑ Choose not to disclose ❑ Something Else: _____

Race: *(choose all that apply)*	Ethnicity:	What is your housing situation today?	Public Housing:
❑ White ❑ Asian ❑ Black/African American ❑ Decline to specify ❑ Native Hawaiian ❑ Other Pacific Islander ❑ American Indian/ Alaska Native ❑ Other, please specify: _____	❑ Hispanic or Latino ❑ Non-Hispanic or Latino	❑ Doubling up ❑ Street ❑ Not Homeless ❑ Transitional ❑ Shelter ❑ I choose not to answer	❑ Yes ❑ No

Mailing Address:	City:	State:	ZIP Code:
Street Address:	**City:**	**State:**	**ZIP Code:**

Parent/ Legal Guardian(s):

Last Name(s)	First:	Middle:	Date of Birth:	Relation:
			/ /	
			/ /	

Address (if different):

Please answer the follwing questions

During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for benefits. Even if you have private health insurance, you may qualify for our Sliding Fee Discount Program for additional discounts:
Annual income $_____ ❑ I choose not to answer this question

How many family members, including yourself, do you currently live with?: _____

IN CASE OF EMERGENCY, CONTACT:

Name:	Relationship to Patient:	Primary Phone:	Alternate Phone:
		( )	( )
		( )	( )

It is CCHCI's policy to only speak with the patient concerning detailed medical information, unless instructed otherwise. Please list the names of any individuals that our office staff has permission from you to release medical information, if none, please check here. ❑ None

Name:	Relationship to Patient:	Primary Phone:	Alternate Phone:
		( )	( )
		( )	( )
		( )	( )

I certify that the information provided on this form is true and correct to the best of my knowledge. I have been given the opportunity to review and receive a copy of the Notice of Patient Practices & Patient Rights and Responsibilities.

_____ / /
Patient/ Legal Guardian Signature *Date*

OFFICE USE ONLY:

Updated on: _____/_____/_____ PSR Printed Name: _____ Revised on: 12/30/19 - N.Escarcega

CHIRICAHUA COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Patient Medical History Form

(Please Print Clearly)

Patient Name _____ Date of Birth ___/___/___ Medical Record # _____

PAST MEDICAL HISTORY

Please complete the information below; if you have any questions, please do not hesitate to ask us.

MEDICAL

Type:	Check one:	Type:	Check one:	Type:	Check one:
Acne	❑ Yes ❑ No	COPD	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
ADD/ADHD	❑ Yes ❑ No	Coronary artery disease	❑ Yes ❑ No	Otitis	❑ Yes ❑ No
Allergies	❑ Yes ❑ No	Depression	❑ Yes ❑ No	PTSD	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Renal disease	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Elevated lipids	❑ Yes ❑ No	Scoliosis	❑ Yes ❑ No
Anxiety	❑ Yes ❑ No	Gallbladder disease	❑ Yes ❑ No	Seizure disorder	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	GERD	❑ Yes ❑ No	SIDS	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Headache, Migraine	❑ Yes ❑ No	Strabismus	❑ Yes ❑ No
Atrial fibrillation	❑ Yes ❑ No	Heart disease	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Clots	❑ Yes ❑ No	Heart valve disorder	❑ Yes ❑ No	Thyroid disease	❑ Yes ❑ No
Bronchitis	❑ Yes ❑ No	Hepatitis/liver disease	❑ Yes ❑ No	UTI	❑ Yes ❑ No
Cardiac arrhythmia	❑ Yes ❑ No	Hypertension	❑ Yes ❑ No	Auto Immune Disease:	
Concussion	❑ Yes ❑ No	Irritable bowel syndrome	❑ Yes ❑ No	Cancer:	
Constipation	❑ Yes ❑ No	Myocardial infraction	❑ Yes ❑ No	OTHER:	

SURGICAL

Type:	Check one:	Type:	Check one:	Type:	Check one:
Angioplasty	❑ Yes ❑ No	Carpal tunnel release	❑ Yes ❑ No	Joint replacement	
Appendectomy	❑ Yes ❑ No	Cataract extraction	❑ Yes ❑ No	Knee replacement	❑ Yes ❑ No
Back surgery	❑ Yes ❑ No	Cholecystectomy(gallbladder)	❑ Yes ❑ No	LASIK	❑ Yes ❑ No
Bilateral tubal ligation	❑ Yes ❑ No	Colectomy	❑ Yes ❑ No	Mastectomy	❑ Yes ❑ No
Blood transfusion	❑ Yes ❑ No	Colostomy	❑ Yes ❑ No	Myomectomy	❑ Yes ❑ No
Breast augmentation/Reduction	❑ Yes ❑ No	Dental surgery	❑ Yes ❑ No	ORIF	❑ Yes ❑ No
CABG	❑ Yes ❑ No	Gastric bypass/ Sleeve	❑ Yes ❑ No	Thyroidectomy	❑ Yes ❑ No
C-Section	❑ Yes ❑ No	Hernia repair/ umbilical	❑ Yes ❑ No	Tonsillectomy/ adenoids	❑ Yes ❑ No
Cardiac pacemaker	❑ Yes ❑ No	Hysterectomy/partial/complete	❑ Yes ❑ No	OTHER:	

Family Health History

Please only list only Mother, Father, Siblings, Grandparents and Immediate Aunts & Uncles. ❑ Adopted ❑ No Family History ❑ UNKNOWN

Type:	Relative:	Type:	Relative:	Type:	Relative:
ADD/ADHD		Depression		Mental illness	
Alcoholism		Developmental delay		Migraines	
Allergies		Diabetes		Obesity	
Alzheimer's disease		Eczema		Osteoporosis	
Arthritis		Elevated lipids		Peripheral vascular disease	
Asthma		Genetic disease		Renal disease	
Blood disorder		Hearing deficiency		Seizure disorder	
Cancer		Hypertension		Stroke	
Cardiovascular disease		Irritable bowel syndrome		Thyroid disorder	
Coronary artery disease		Learning disability			

ALLERGIES & REACTIONS

If allergic to any medications or food, please specify below

Medication/Food	Reaction

MEDICATIONS

Prefered Pharmacy Name: _____ Pharmacy Location: _____

Please list ALL medications along with units you are currently taking: *(example: Aspirin 25mg)*

Medication Name:	Units:	Medication Name:	Units:

OFFICE USE ONLY

Medical History Reviewed on: ____/____/____ MSS Printed Name: _____

Created: 12/05/2017-L.R.

CHIRICAHUA COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Financial Agreement
(520) 364-1429

Patient's Name: _____ Date of Birth: ____/____/____ MRN: _____

Welcome! Thank you for selecting Chiricahua Community Health Centers, Inc. (herein also referred to as CCHCI) as your medical/dental health care provider. Our goal is to provide you and your family with optimal care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions, be involved in treatment decisions, and understand your insurance benefits. This includes understanding your treatment plan as well as our financial policy.

_____ (Initial Here) As the financially responsible party, I understand and agree to the following payment terms.

During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for benefits. Even if you have private health insurance, you may qualify for our Sliding Fee Discount Program for additional discounts: Annual income $_____ ❑ I choose not to answer this question.
How many Family members, including yourself, do you currently live with? _____

Dental Payment Terms

Patients without insurance coverage

70% of the estimate for the treatment rendered must be paid in full on the date of service for patients who are not enrolled in the Sliding Fee Discount Program (SFDP).

Patients with insurance coverage

65% of the estimated patient coinsurance and/or deductible for the treatment rendered must be paid in full on the date of service for patients who are not enrolled in the Sliding Fee Discount Program (SFDP).

Copayments and fee schedule amounts are due in full at the time of service.

Prompt payment incentive

75% payment of the estimated **FULL** charges prior to the receipt of services rendered will be considered paid in full. I also understand there will be a fee for any additional procedure NOT included in the original treatment plan.

Medical Payment Terms

Patients without insurance coverage

$80 must be paid in full on the date of service for patients who are not eligible for the Sliding Fee Discount Program (SFDP).

Patients with insurance coverage

Payment in full is required at the time of service for all copayment, deductible, and/or co-insurance amounts that have not been met, and any coverage that could not be verified at the time of service.

Prompt payment incentive

$85 must be paid in full on the date of service. Services **NOT** covered are:

- Prescriptions
- Radiology services not provided directly by a CCHCI provider
- Laboratory services sent to an outside laboratory
- Services not provided directly by a CCHCI provider

Additional Payment Terms

Payment Options

We accept Visa, MasterCard, Discover, American Express, checks, and cash for payment of the amount due. If you would like more information regarding our SFDP program, ask one of our receptionists.

Outstanding Balances

All outstanding balances require payment in full or a payment plan prior to services being rendered. Service can be denied if account is not current. I understand that I am ultimately responsible for all fees generated by my treatment and/or services rendered. All of our providers will render services based on the recommended guidelines pertaining to your health and not based on your insurance coverage.

CHIRICAHUA COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Financial Agreement
(520) 364-1429

Patient's Name: _____ Date of Birth: ____/____/____ MRN: _____

Registration: All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license or picture ID and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within thirty (30) days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

Dental Treatment Plans: You understand that if Chiricahua Community Health Centers, Inc. has treatment recommendations for you, you will receive an itemized list of the recommended treatment. This will also contain an estimate of what the fees will be for the recommended treatment. If you have dental insurance, the treatment plan may include an additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. You understand that treatment plan estimates are not a guarantee of insurance payment and you are ultimately responsible for all fees generated by your treatment.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued.

Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within ninety (90) days after the date of service, the full amount is due and payable by you. We will promptly refund to you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees that we incur plus all court costs. In case of suit, you agree the venue shall be in Cochise County, Arizona.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, or if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned Checks: There is a service fee (currently $25) for any checks returned by the bank.

Insurance Release: You authorize Chiricahua Community Health Centers, Inc. to release any necessary information requested by your insurance carrier and authorize payment directly to Chiricahua Community Health Centers, Inc. for any benefits available under your insurance plan.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Consent to treat:

**** This is an agreement between Chiricahua Community Health Centers, Inc. and the patient and/or legal guardian named on this form. By executing this agreement, you consent to treatment by CCHCI and staff and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.***

Responsible Party's Name (PRINT)
(Patient or parent/guardian if patient is a minor)**:** _____

Signature: _____ Date: _____/_____/_____

CHIRICAHUA
COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Release of Information

AUTHORIZED PERSONNEL ONLY

☐ Mailed ☐ Patient Paid ☐ Hand Carried ☐ Verbal consent

☐ Faxed ☐ CD ☐ Alert Created ☐ PHI Log

Date Entered: _____ **Completed By**: _____

Page Count: _____ Certified Mail #: _____

Patient's Full Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____ Email Address: _____

To provide information TO/FROM:

Person/Provider: _____

Address: _____

Fax Number: _____

Phone Number: _____

This authorizes:

Person/Provider: **Chiricahua Community Health Centers Inc.**

Address: **1205 F Ave., Douglas, AZ 85607**

Fax Number: **(520) 515-8690**

Phone Number: **(520) 364-6862**

General Permissions: ☐ Medical ☐ Dental

☐ 3 months of the most recent records
☐ Labs Dates (from) _____ (to) _____
☐ Other (please be specific): _____

☐ All records (only 2 years, unless other dates are specified)
☐ X-rays: Dates (from) :_____(to):_____

No more than 50 pages via fax. If more than 50 pages, please mail.

Special Permissions:

Mental/Behavioral Health Services

☐ All mental/behavioral health/psychotherapy records
☐ Only psychotherapy records
☐ I want to review these records before they are released. I understand my review will be supervised in the Health Information Management Department.
☐ Do not release this information

Please Note: Arizona Law does allow CCHCI to share this information within our organization to other health care providers to coordinate your care.

Drug/Alcohol/Medication Assisted Therapy

☐ Include all Drug/Alcohol/MAT records
☐ Include only the specific information:
  ☐ Clinical Notes and Discharge Summaries (including therapy notes)
  ☐ Lab & Other Diagnostic Test Results
  ☐ Assessment/Screening Results
☐ Do not release this information

HIV/AIDS Information

☐ Include this information in the release
☐ Do not release this information

Purpose for need of disclosure:

☐ At the request of the individual to transfer care
☐ At the request of the individual to coordinate care
☐ Verbal consent permitted by patient or representative

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, **42 C.F.R. Part 2**, and the **Health Information Portability and Accountability Act (HIPAA)**, **45 C.F.R. Parts 160 and 164**, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations.

I understand that **I have a right to revoke this authorization** at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocations will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: ___/___/___, or if I fail to specify an expiration date, **this authorization will expire in one (1) year.**

I understand that authorizing the disclosure of this health information is voluntary. **I can refuse to sign this authorization.** I need not sign this form in order to assure treatment. I understand that I may inspect or request copies of the information to be used or disclosed, as provided in **CFR 164.524.** I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

Signature of Patient/Parent or Guardian _____ Relationship to Patient _____ Date _____

Witnessed _____ Job Title _____ Date _____

CHIRICAHUA
COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Sliding Fee Discount Program SFDP
FMP Title X – Adolescent Application

A. List Immediate family members residing in household

Full Name	DOB	Relation to Patient	Marital Status	7 Day Eligible	Medical Record #	Med/Den Eligible
# *Jane FMP Doe*	*02/30/2000*	***Example***	❑M ❑S	❑Y ❑N	*123*	☑Med ❑Den ❑N/A
1		**SELF**	❑M ❑S	❑Y ❑N		☑Med ❑Den ❑N/A
2			❑M ❑S	❑Y ❑N		❑Med ❑Den ❑N/A
3			❑M ❑S	❑Y ❑N		❑Med ❑Den ❑N/A
4			❑M ❑S	❑Y ❑N		❑Med ❑Den ❑N/A
5			❑M ❑S	❑Y ❑N		❑Med ❑Den ❑N/A
6			❑M ❑S	❑Y ❑N		❑Med ❑Den ❑N/A
7			❑M ❑S	❑Y ❑N		❑Med ❑Den ❑N/A
8			❑M ❑S	❑Y ❑N		❑Med ❑Den ❑N/A
9			❑M ❑S	❑Y ❑N		❑Med ❑Den ❑N/A

B. Income Information

Person Receiving Income

Amount $_____
- ❑ Weekly
- ❑ Bi-weekly
- ❑ Monthly
- ❑ Annually
- ❑ Other

Employer/ Source of Income Phone #

Address City/State/Zip

Person Receiving Income

Amount $_____
- ❑ Weekly
- ❑ Bi-weekly
- ❑ Monthly
- ❑ Annually
- ❑ Other

Employer/ Source of Income Phone #

Address City/State/Zip

C. Statement of Self Declaration

Applicant Name

Address

City/State/ Zip Code

(_____)_____-_____
Phone #

I verify that the information that I have provided is true and correct to the best of my knowledge.

There are _____ adults and _____ children in my household.

I am: ❑ Farm Worker ❑ Homeless

Signature:_____ Date:_____/_____/_____

Witness Signature:_____ Date:_____/_____/_____

D. Office Use Only:

1. Annual Income: $_____ 2. HH Size:_____ 3. FPL:_____% 4. Payer Assigned: ☑1yr. SFDP ❑7 Day SFDP ❑**340B**

5. Eff. Date:____/____/____ **6.Exp. Date:**_____/____/____ **7. MR #**_____ 8. Employee Name:_____

CHIRICAHUA
COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Patient Registration Form

Migrant/Seasonal Farmworker Information

Farm Worker Definition:
People who work, or have worked, within the **last two years** in agriculture. This includes the workers' **family members**. Agriculture means farming in all its branches including: **Horticulture**, **Aquaculture**, **Animal Husbandry**, **Packing and Delivery** to a location for sale or processing.

Examples of Agriculture Workers in Cochise County:
Fiesta Canning, Coronado Farms, NatureSweet, FICO, The Pharm, Pistachios, Pecans, Grapes, or other fields.
Excluded Trasks: Meat and Meat Products Industries, Horse Racing, Landscaping, Trucking or Timber Industry

1. Have you or a family member worked in these areas in the last two years?
   a. ❑ Preparing Soil ❑ Seeding ❑ Planting ❑ Canning ❑Preserving ❑Not Applicable
   b. ❑ Transporting ❑ Feeding ❑ Milking ❑ Caring for Farm Animals

2. Are you Retired or Disabled from working in Agriculture? _____

Farm worker Categories:
Section 330g of Public Health Service Act has two definitions for farm workers.
Please mark which one applies for you or your family member:
1. ___**Migrant Worker**: your **principal employment**, in the **last 24 months**, is in agriculture, and you **established a temporary home** for the purpose of such employment.
2. ___**Seasonal Worker:** means your **principal employment** in the **last 24 months**, is in agriculture, you work on a **seasonal basis**, and you have **not established a temporary home** in order to work in agriculture.

Definición de Trabajador Agrícola
Personas que trabajan o han trabajado en los **últimos dos años** en agricultura. Esto incluye, la **familia** del trabajador**.** Agricultura significa las siguientes áreas: **horticultura, acuacultura, cría de animales, empaque** y **transportacion para venta o procesamiento**.

Ejemplos de Empleos Agrícolas en el Condado de Cochise:
Fiesta Canning, Coronado Farms, NatureSweet, FICO, The Pharm, Pistachos, Nueces, Uva y otros campos.
No Incluye: Proceso/empaque de carnes, carreras de caballos, jardinería, camiones e industria maderera

1. ¿Ha trabajado usted o un miembro de su familia en estas áreas en los últimos dos años?
   a. ❑ Preparación de la tierra ❑ Sembrar ❑ Plantar ❑ Empacar ❑ Conservar ❑ no aplica
   b. ❑ Transportar productos ❑ Alimentación ❑ Ordeña ❑ Cuidado de animales de granja

2. ¿Está jubilado o discapacitado por trabajar en el campo? ____

Categorías de trabajadores agrícolas
La Sección 330g de la Ley del Servicio de Salud Pública tiene dos definiciones para los trabajadores agrícolas, **Por favor conteste lo que aplique a usted y/o su familia**
3. ___ **Trabajador Migrante**: **Principal empleo**, en los últimos **24 meses**, fue en agricultura, y tiene un **hogar temporal** para ese trabajo
4. ___ **Trabajador Estacional**: **Principal empleo** en los últimos **24 meses**, fue en agricultura, y es **por temporadas,** y no tienen un hogar temporal y para su trabajo.

Patient's Name: _____ Date of Birth: ____/____/____ MRN: _____

CHIRICAHUA
COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Notice of Patient Privacy Practices

This notice describes your rights as a patient at Chiricahua Community Health Centers, Inc. (CCHCI) and this notice is followed by our employees, staff and other personal under the Federal Health Insurance Portability and Accountability Act, (HIPAA) Notice of Privacy Practices for Protected Health Information. This notice also describes how your health information may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Understanding Your Health Record/Information

What is in your health care record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and for you to make better informed decisions when authorizing disclosure to others.

Each time you visit one of our office locations a record of your visit is made. This record includes, but is not limit to your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as "your health record", may be used or shared by our practice for the following reasons:

- A basis for planning your care and treatment.
- A means of communication among health professionals inside and outside of CCHCI, to include health care/ behavioral health providers and clinical care coordinators who contribute to your care.
- A legal document describing the care we provided to you.
- A record that you or a third-party payer can verify that services billed for were actually provided.
- A training 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 this county, state and the nation.
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve.
- To provide you with information on additional treatment alternatives and other health related benefits.
- We may use your information for appointment reminders as defined by the "consent" section of the patient registration form.

Your Health Information Rights:

Although your health record is the physical property of this organization, the information belongs to you. You have the right to:

- Obtain a copy of this "Notice of Patient Privacy Practices"
- Right to request an amendment to your health information record. If you believe health information, we have about you is incorrect or incomplete, you may ask us to amend the information.

You have the right to request an amendment as long as the information is stored by CCHCI. To request an amendment, obtain a medical record amendment/correction form from any staff member; complete and return the request to the CCHCI Risk Manager. We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that: We did not create, unless the person or entity that created the information is no longer available to make the amendment, is not part of the health information that we keep, you would not be permitted to inspect and copy, or is accurate and complete. If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be 10 pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request including rebuttal, be transmitted to any other party any time that portion of the medical record is disclosed.

- Inspect and/or receive a paper or electronic copy of your health record upon request as provided for in 45 Code of Federal Regulations (CFR) 164.512 and 45 CFR 164.524 (HIPAA).
- If your request to inspect or receive a copy of your healthcare record is approved, we will contact you and provide you with supervised access to your medical record. We will provide a copy or a summary of your healthcare information, within 30 days of your request. We may charge a reasonable, cost-based fee. In certain situations, such as; if providing access would cause harm, we can deny access. You do not have a right of access to the following:

Mental Health or Psychotherapy notes. Such notes comprise those that are recorded in any medium by a health care professional who is a mental health professional documenting or analyzing a conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of your medical record.

Information compiled in reasonable anticipation of or for use in civil, criminal or administrative actions or proceedings.

PHI (protected health information) that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42

U.S.C § 263a, to the extent that the provision of access to the individual would be prohibited by law.
Information obtained from someone other than a health care professional under the promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.
In other situations, the provider may deny you access but, if the provider does, the provider must provide you with a review of the decision denying access. These "reviewable" grounds for denial include:
Licensed healthcare professional has determined, in the exercise of professional judgment that the access is reasonably likely to endanger the life or physical safety of the individual or another person.
• If you choose to use the Patient Portal, you are responsible for maintaining the confidentiality of your account and password and for restricting access to your account, and you agree to accept responsibility for all activities that occur under your account. We do not sell or rent or share personally-identifying information collected during your use of Patient Portal without your permission. A full patient portal privacy policy is available on the NextGen Patient Portal website.
• Obtain an accounting of disclosures of your health information. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement. To obtain this list, you must submit your request in writing to the Privacy Officer. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For Additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
• Request confidential communications of your health information by alternative means or at alternative locations.
• Request a restriction on certain uses and disclosures of your information. The right to request a restriction does not extend to uses and disclosures permitted or required under subsection §§ 164.512 (uses and disclosures required by law, for mandatory communicable disease reporting), in these cases, you do not have the right to request restriction certain information to health plans if you fully paid for these services out of pocket.
• Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
• You have a right to opt out of communications for fund raising activities of this practice.
CCHCI will participate in Notice of Health Information Practice (HIO Notice) as is in accordance with 42CFR part 2. CCHCI is authorized to disclose all or parts of your record, including without limitation, information pertaining to substance abuse, psychiatric, HIV and other information, in accordance with federal, state and other applicable laws including HIPAA. Some of your health information will be sent to Health Current, unless you opt out in writing.

Our Responsibilities

We are required to:

• Maintain the privacy of your health information as defined by federal and state laws.
• Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
• Notify you of a breach of your protected health care information.
• Notify you if we are unable to agree to a requested restriction.
We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request, we will provide you with a revised "Notice of Patient Privacy Practices."

To Report a Problem If you believe your privacy rights have been violated, you may file a complaint by calling our Compliance Hotline 1-520-515-8662 ext. 7599. Or with the Secretary of the Department of Health and Human Services at: Office for Civil Rights Region X U.S. Department of Health and Human Services 2201 Sixth Avenue – Mail Stop RX-11 Seattle, WA 98121 (206) 615-2290; (206) 615-2296 (TDD). There will be no retaliation for filing a complaint.

Treatment, Payment and Health Operations:

Treatment: Information obtained by a member of our health care team will be recorded in your record and will be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment, copies of your health care information to assist them in treating you.

• **Payment:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as, your diagnosis, procedures, and supplies used.

• **Healthcare Operations:** Members of the medical staff may use or disclose information in your health record to assess the care and outcomes in your case and others like it. This information may be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

• **Business Associates:** There are some services provided to our organization through contracts with business associate(s). When these services are contracted, we may need to use or disclose your health information to our business associate(s) so they can perform the job we've hired them to do. HIPAA now requires the business associate to protect your health information just as we do. Therefore, this practice requires the business associate, their agents, subcontractors and representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by federal and state law.

• **Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal and state law and the "consent" section of the patient registration form).

• **Communication with Family:** Our health care professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care, as governed by federal and state law.

• **Research:** We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

• **Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

• **Workers Compensation:** We may use or disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

• **Public Health:** As required by law we may disclose your health or legal information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

• **Correctional Institution:** Should you be an inmate of a correctional institution; we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

• **Law Enforcement:** We may use or disclose your PHI as required by law or required by a court ordered subpoena.

• **Abuse and Domestic Violence:** As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities health care information related to possible or known abuse or domestic violence.

• **Authorization:** We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV/AIDS status, drug and alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.

CHIRICAHUA
COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Patient Rights and Responsibilities

It is the policy of Chiricahua Community Health Centers, Inc. (CCHCI) to clearly outline the rights (as per Arizona Administrative Code Title 9, Chapter 10, Article 10) and responsibilities of our patients.

A. An administrator shall ensure that:
   1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
   2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
   3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
      a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
      b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:
   1. A patient is treated with dignity, respect and consideration;
   2. A patient is not subjected to:
      a. Abuse;
      b. Neglect;
      c. Exploitation;
      d. Coercion;
      e. Manipulation;
      f. Sexual Abuse;
      g. Sexual Assault;
      h. Except as allowed in R9-10-1012(B), restraint or seclusion;
      i. Retaliation for submitting a complaint to the Department or another entity; or
      j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
   3. A patient or the patient's representative:
      a. Except in an emergency, either consents to or refuses treatment;
      b. May refuse or withdraw consent for treatment before treatment is initiated;
      c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
      d. Is informed of the following:
         i. The outpatient treatment center's policy on health care directives, and
         ii. The patient complaint process;
      e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
      f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
         i. Medical record, or
         ii. Financial records.

C. A patient has the following rights:
   1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status or diagnosis;
   2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
   3. To receive privacy in treatment and care for personal needs;
   4. To review, upon written request, the patient's own medical record according to A.R.S.§§ 12-2293, 12-2294, and 12-2294.01;
   5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
   6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
   7. To participate or refuse to participate in research or experimental treatment; and
   8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting or exercising the patient's rights.

D. A Patient has the following responsibilities:
   1. Provide information about past illnesses, hospitalization, medication, and other matters relating to your health history to effectively treat your illness.
   2. Cooperate with all healthcare facility personnel and ask questions if directions and/or procedures are not clearly understood.
   3. Be considerate of other patients and healthcare center personnel. Patients are also expected to be respectful to the property of other persons and the property of the healthcare facility.
   4. Help the physicians, nurses, and allied medical personnel in their efforts to care for you by following their instructions and medical orders.
   5. Name authorized members of your family to be available to healthcare facility personnel for review of your treatment in the event you are unable to properly communicate with the physicians or medical support staff.
   6. Assume the financial responsibility of paying for all services rendered either through third-party payers (e.g., an insurance company) or being personally responsible for payment for any services that are not covered by your insurance policies.
   7. Refrain from the use of drugs that have not been prescribed by your attending physician and administered by healthcare center staff.
   8. Not complicate or endanger the healing process by consuming alcoholic beverages (unless authorized by your physician) or toxic substances.