



CHIRICAHUA

COMMUNITY HEALTH CENTERS, INC.

HEALTH FOR ALL

Patient Registration Form

(Please Print Clearly)

We want to make sure that we identify and address each patient's individual needs and ensure that all our patients get the best care possible. We are going to ask you some questions about yourself such as: your name, your age, your address, your language preference, your gender identity, your race, your ethnicity and so on. Learning about the sexual orientation and gender identity of our patients helps us to better understand the populations that we are serving. It also allows us to offer culturally responsive care that focuses on your needs. We will keep this information confidential and will update it in your medical record at Chiricahua Community Health Centers, Inc. for improved care and services and to prevent discrimination. The only people who see this information will be members of your care team and others who are authorized by you to see your medical record as regulated by privacy laws. -----

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:
			/ /	<input type="checkbox"/> Single <input type="checkbox"/> Married
Preferred Name:				<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
(Required for patients with Medicare) Social Security Number: - -				

Mobile Phone: ()	Home Phone: ()	Work Phone: ()	Email Address:
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Birth Gender:	Current Gender:	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	

Mailing Address:	City:	State:	ZIP Code:
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Street Address:	City:	State:	ZIP Code:
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Parent/ Legal Guardian(s):

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

Address (if different):

IN CASE OF EMERGENCY, CONTACT:

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

It is CCHCI's policy to only speak with the patient concerning detailed medical information, unless instructed otherwise. Please list 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:
		() -	() -
		() -	() -

Preferred Pharmacy:

- ☐ Chiricahua Benson Pharmacy ☐ Chiricahua Sierra Vista Pharmacy
- ☐ Chiricahua Bisbee Pharmacy ☐ Other : _____
- ☐ Chiricahua Douglas Pharmacy

Billing Communication Consent / I consent to receive billing related communications

☐ Accept ☐ Decline

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: 2/3/25 - J.King/NE





CHIRICAHUA

COMMUNITY HEALTH CENTERS, INC.

HEALTH FOR ALL

Medical Consent to Treat Form

Patient Registration Form

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

You have the right, as a Chiricahua Community Health Centers, Inc. (CCHCI) patient, to be informed about your condition and any recommended surgical, medical, or diagnostic procedure to be used so that you may make an informed decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that:

1. You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and /
2. You consent to treatment at this office, telehealth, home visitation, or any other office location under CCHCI operation.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your CCHCI health care provider, we encourage you to ask questions and provide feedback via our cchci.org website

I voluntarily request a physician, and/or mid-level provider, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at CCHCI.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. Family Planning services are available on a voluntary basis and are not a pre-requisite to other health center services.

As an organization who participates in clinical training, you or your family member may encounter a trainee while receiving care. If you do not want a trainee to participate in your care, please notify the clinic manager or your provider at the time of your visit.

*Signature **

Date

OFFICE USE ONLY:

Updated on: ____/____/____ PSR Printed Name: _____

Revised on: 05/17/23 – J.King





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/mental 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.

Medical and Psychiatric Payment Terms (Effective 12/2/2024)

Patients without insurance coverage: \$125 must be paid in full on the date of service, prior to receiving services, for patients who are not eligible for the Sliding Fee Discount Program (SFDP). A payment agreement will be set up for the remaining amount after the visit.

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: \$130 must be paid in full on the date of service, prior to receiving services. Services **NOT** covered are: prescriptions, laboratory services sent to an outside laboratory, birth control, vaccines, any services not provided directly by a CCHCI provider.

Dental Payment Terms (Effective 11/18/2024)

Patients without insurance coverage: 85% of the estimate for the treatment rendered must be paid in full prior to receiving services on day of service for patients who are not enrolled in the Sliding Fee Discount Program (SFDP). A payment agreement will be set up for the remaining 15% after the visit.

Patients with insurance coverage: 100% 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: 90% 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.

Mental Health, Dietetic Health and Counseling Payment Terms (Effective 1/1/2025)

Patients without insurance coverage: \$95 for initial evaluations and \$55 for follow-up visits 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: \$100 for initial evaluations and \$60 for follow-up visits 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.



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: ____/____/____



Patient Medical History Form

(Please Print Clearly)

Patient Name

Date of Birth

File #

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

SURGICAL

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

Preferred Pharmacy Name:

Pharmacy Location:

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

Medication Name:	Units:	Medication Name:	Units:





CHIRICAHUA

COMMUNITY HEALTH CENTERS, INC.

HEALTH FOR ALL

UDS Form

Patient Registration Form

Patient's Name/ Nombre de Paciente: _____ Date of Birth/ Fecha de Nacimiento: ____/____/____ MRN: _____

As a Federally Quality Health Center, Chiricahua is required to ask you specific questions regarding your income, race, ethnicity, sexual orientation, housing, veteran, and farmworker status in an effort to better understand the population that we serve and to verify your eligibility for additional programs and services. / Como centro de salud de calidad federal, Chiricahua debe hacerle preguntas específicas sobre sus ingresos, vivienda, estado de veterano y trabajador agrícola en un esfuerzo por comprender mejor a la población a la que servimos y verificar su elegibilidad para programas y servicios adicionales.

1. **What is your housing situation today? (please circle one)/¿Cual es su situación de Vivienda el día de hoy? (circule uno):**

- a. Doubling up (Temporarily Living with Others / Duplicación (viviendo temporalmente con otros)
- b. Not Homeless / No viviendo en la calle
- c. Permanent Supportive Housing / Vivienda de Apoyo Permanente
- d. Homeless Shelter / Refugio para indigentes
- e. Living on Street Or In Vehicle / Vivir en la calle o en vehículo
- f. Transitional Housing / Vivienda de Transición
- g. Homeless But Arrangement Unknown / Sin hogar pero arreglo desconocido
- h. Other (No Longer Homeless, But Homeless Within Past 12 Months) / Otra (ya no tiene hogar, pero sin hogar en los últimos 12 meses)
- i. Other _____

Farm Worker Definition / Definición de Trabajador Agrícola:

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. / 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, acuicultura, cría de animales, empaque y transportación para venta o procesamiento.

2. **Which farm worker category best describes you or your family member? /¿Que categoria de trabajador agrícola lo describe mejor a usted o a su familiar? (circule uno)**

- a. Migratory Farmworker in Last 24 Months (Temporary Housing When Employed) / Trabajador agrícola migratorio en los últimos 24 meses (vivienda temporal cuando está empleado)
- b. Not a migrant or seasonal farm worker / No es un trabajador agrícola migrante o de temporada
- c. Seasonal Farmworker in Last 24 Months (Paid Hourly, daily, no Temporary Housing) / Trabajador agrícola de temporada en los últimos 24 meses (pago por hora, por día, sin alojamiento temporal)

3. **Patient Do you have a language barrier? (Do you require language interpretation assistance)? / ¿Tienes una barrera del idioma? (¿Necesita asistencia de interpretación de idiomas)? (circule uno)**

- ☐ No/ No
- ☐ Yes/ Si

4. **Patient Race (please select all that apply) / Raza del paciente (por favor seleccione todas las opciones que apliquen)**

- a. American Indian or Alaska Native / Indio americano o nativo de Alaska
- b. Asian Indian / Indio asiático
- c. Black or African American/ Negro o afroamericano:
- d. Chinese / Chino
- e. Filipino / Filipino
- f. Guamanian or Chamorro (Mariana Islands, Saipan, Tinian, Rota) / Guamanian o Chamorro (Islas Marianas, Saipan, Tinian, Rota)
- g. Japanese/ Japoneses
- h. Korean / Coreano



- i. Native Hawaiian / Nativo Hawaiano
- j. Other Asian / Otro asiático
- k. Other Pacific Islander (Tonga, Melanesia, Oceania)/ Otro isleño del Pacífico (Tonga, Melanesia, Oceania)
- l. Prefer Not To Disclose Race / Prefiero no revelar la raza
- m. Samoan / Samoano
- n. Vietnamese / Vietnamita
- o. White/ Blanco

5. Patient Ethnicity (please select all that apply) / Origen étnico del paciente (por favor seleccione todas las opciones que apliquen):

- a. Another Hispanic, Latino/a Or Spanish Origin / Otro origen hispano, latino/a o español
- b. Mexican/ Mexican American, Chicano/a / Mexicano / mexicano americano, chicano / a
- c. Cuban/ Cubano
- d. Prefer Not to Disclose Ethnicity / Prefiero no revelar el origen étnico
- e. Not Hispanic or Latino/a, Or Spanish Origin / No hispano o latino / a, u origen español
- f. Puerto Rican / Puertorriqueño

Patient Veteran Status:

6. Have you ever served, or are currently serving, in the United States military? (please circle one) / ¿ Ha servido alguna vez, o esta sirviendo actualmente, en las fuerzas armadas de los Estados Unidos? (circule uno)

- a. No (Never Served or Patient Was Active Last Year and Last Visit) / No (nunca atendido o el paciente estuvo activo el año pasado y la última visita)
- b. Yes (Previously Served US Military or Armed Forces) / Sí (anteriormente sirvió en las Fuerzas Armadas o militares de los EE. UU.)

7. During the past year, what was the total combined income for you and the family members that you live with? This information will help us determine if you are eligible for additional benefits. Even if you have private health insurance, you may qualify for our Sliding Fee Discount Program for additional discounts. / Durante el último año, ¿cual ha sido el total de ingresos combinados de usted y familiares que viven con usted? Esta información nos ayuda a determinar si usted es elegible para ciertos beneficios. Aun si tiene seguro de salud privado, usted puede calificar a nuestro programa de descuentos 'Sliding Fee Discount Program' para descuentos adicionales

Household Income/ Ingresos del hogar: \$ _____

Family Size / Tamaño de la familia: _____

☐ Refused to Report / Negarse a informar





Patient Name: _____ Date of Birth: _____ MRN: _____

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 records
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.

A patient has the following responsibilities:

1. Provide information about past illnesses, hospitalizations, medication, and other matters related to your history to effectively treat your illness.
2. Cooperate with all healthcare facility personnel and ask questions if direction 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 the 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 payors (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.

Patient Signature: _____ Date: _____



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 personnel 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 limited 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.