summit community
CARE CLINIC

PATIENT REGISTRATION

Patient's Last Name:	First Name:	Middle Initial:	Date of Birth:	Sex at Birth: M F	Are you a Veteran? Y N

Email Address:	Social Security No:

Mailing Address:	Apt/Unit #	City:	State:	Zip Code:
Physical Address:	**Apt/Unit #**	**City:**	**State:**	**Zip Code:**

Please mark the check box for your preferred phone number:

☐ Cell Phone:_____ ☐ Home Phone: _____ ☐ Other Phone: _____

Insurance: ☐ I do not have health insurance

	Primary Medical/Behavioral Health	Secondary Medical/Behavioral Health	Dental
Name			
ID #			
Group #			

Pharmacy Name, City, State, Zip Code:

Name: _____

Address: _____

_____

Phone: _____

Employment status:

Employed Unemployed Retired

Student Self-employed Seasonal

Student Child

Migratory/ Seasonal agricultural worker

Parent or Guardian or REsponsible Party for those under 18 years old:

Name: _____

Address: _____

_____

Phone #: _____

Date of Birth: _____

Relationship: Spouse Child Other

HOUSEHOLD INCOME AND FAMILY SIZE

Estimated Household Income (before taxes)

☐ Weekly _____ ☐ Monthly _____ ☐ Annual _____

Number of financial dependents living in your household (including yourself)

PLEASE CIRCLE:

RACE (CIRCLE ONE)	PRIMARY LANGUAGE (CIRCLE ONE)	ETHNICITY (CIRCLE ONE)	GENDER IDENTITY (CIRCLE ONE)	SEXUAL ORIENTATION (CIRCLE ONE)
AMERICAN INDIAN OR ALASKA NATIVE	AMERICAN SIGN LANGUAGE	HISPANIC OR LATINO	CHOOSE NOT TO DISCLOSE	BISEXUAL
ASIAN	ENGLISH	NOT HISPANIC OR LATINO	FEMALE	CHOOSE NOT TO DISCLOSE
BLACK OR AFRICAN AMERICAN	FRENCH	NOT PROVIDED	GENDERQUEER	DO NOT KNOW
NATIVE HAWAIIAN	SPANISH		MALE	LESBIAN OR GAY
OTHER PACIFIC ISLANDER	OTHER:		OTHER	SOMETHING ELSE
WHITE			TRANSGENDER WOMAN/TRANSGENDER FEMALE	STRAIGHT OR HETEROSEXUAL
			TRANSGENDER MAN/TRANSGENDER MALE	

IN CASE OF EMERGENCY

Please tell us who to contact in case of an emergency (parent or guardian if patient is under 18). An emergency would be severe bleeding, unconsciousness, accident or a condition requiring transport or hospitalization. Family planning services DO NOT require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian.

Does the person listed below know that you are receiving services here? ☐ Y ☐ N

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ PHONE # _____

PATIENT REGISTRATION FORM, continued

Patient's Last Name: First Name:	Date of Birth:

CONSENTS

In order to establish you as a patient of Summit Community Care Clinic (SCCC) , please review each of the statements below, initial them and sign at the end that you consent to SCCC's policies. Copies of all policies are provided to you in printed format and may also be found on

ACKNOWLEDGEMENT AND RECEIPT OF PRIVACY PRACTICES:

I acknowledge receiving and reading a complete copy of the Notice of Privacy Practices of SCCC. I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices. Initials _____

CONSENT FOR HEALTHCARE:

I acknowledge receiving and reading a complete copy of the Treatment Consent , Consent to Participate in Telehealth for Medical, Dental, and Behavioral Health. I voluntarily consent to Medical, Dental or Behavioral Health treatment, laboratory procedures, administration of medication, and other health services that may be ordered by a Medical, Dental and Behavioral Health Providers participating in my care.

Initials _____

ACKNOWLEDGEMENT AND RECEIPT OF FINANCIAL AGREEMENT:

I acknowledge receiving and reading a complete copy of the Financial Agreement. I hereby authorize payment to SCCC of insurance benefits. I accept responsibility for any unpaid balances left on my account regardless of the amount of insurance coverage. I am responsible for any charg- es of service and agree to pay for services at the time of service. Initials _____

NO SHOW POLICY:

I acknowledge receiving and reading a complete copy of the No Show Policy. I further acknowledge that, as of today's date, I have no questions regarding the No Show Policy. Initials _____

I UNDERSTAND that my Personal Health Information (PHI) will be released only with my authorized signature on a records release form. Many insurance companies may require release of PHI in order to pay claims. If you choose not to release confidential PHI and the insurance company will not pay the claim for those services, you will be liable for those charges. I understand that my PHI will be shared via a Health Information Exchange (HIE) to ensure continuity of care between hospitals, specialty medical groups and Providers. Please inform staff if you do not want this. Initials _____

I AUTHORIZE SCCC to contact me via patient portal or phone with medical information and for overdue care reminders. I understand that charges from my cell phone carrier may apply. Initials _____

I UNDERSTAND the risks of using email and agree that email messages may include the protected health information about me, or the patient named on this registration. I understand that email should not be used for urgen or emergent situations. Initials _____

I AUTHORIZE SCCC throught its vendor RavePoint to contact me by SMS text message to serve me better. I understand that message/ data rates apply and I could receive up to 10 messages per month. I may contact SCCC if I choose to not receive text messages. Initials _____

I certify,

that the above information is true, accurate, and complete to the best of my knowledge, (incorrect or false information will result in termination of services). I permit Summit Community Care Clinic representatives to contact any necessary person or agency to verify this information. If further information is needed, I must furnish it within 30 days.

If you are completing this form for another person, what is your relationship to that person?

Your name _____ **Relationship** _____ **Phone #** _____

PATIENT SIGNATURE **X** _____ **DATE** _____

Summit Community Care Clinic Informed Consents

I, do hereby give my consent to the Medical, Behavioral Health and Dental staff at Summit Community Care Clinic (SCCC) to examine, treat and counsel me.

I understand and agree with the following:

- I understand there are certain hazards and risks connected with all forms of medical treatment and care, which may result in additional costs to me (the client).
- I agree to a physical exam, if one is recommended.
- I understand that all information about me will be kept in strictest confidence and will not be released to anyone without my permission, except as required by law. This could include:
    - positive test results of some sexually transmitted diseases,
    - sexual or physical abuse of minors, or
    - physical signs of domestic violence.

Family Planning:

- I understand that covered family planning services include routine family planning visits to initiate, continue or discontinue a contraceptive method. Additional covered family planning services may include, but are not limited to, provision of contraceptive methods and pregnancy testing and counseling.
- I understand that there is no guarantee of payment by insurance or by an aid program for any costs that the family planning program does not cover and for which I am responsible.
- I understand that I may be billed for non-Title X services including but not limited to: colposcopy, HIV testing, Chlamydia screening if not at risk, complications resulting from Title X-covered procedures, side effects, from medications, etc.
- I understand that my provider may recommend lab tests if indicated, some of which may be covered by the family planning program. My provider will discuss these with me.
- I understand that this agency may use a statewide database that makes my health information available to the state health department and other participating family planning programs in Colorado. The benefit to me is that I can change to another participating family planning clinic and that clinic can access the health information I have already shared.

Female clients only:

- I agree to have a pelvic examination including a Pap smear, if recommended. I understand a Pap smear may not be recommended every year.
- I understand that the test for cancer of the cervix (Pap smear) is a screening test only and may produce false negatives (cancer is present but the test says it is not) as well as false positives (cancer is not present but the test says it is).
- I understand the Pap smear may not have enough information to make a diagnosis and may have to be done again.

Telehealth:

- I understand that my primary health care provider at the SCCC may wish me to engage in medical, dental, and behavioral health care visits via telehealth.
- My health care provider will explain to me how the video conferencing technology will be used during any telehealth visits I participate in. I understand that telehealth appointments will not be the same as a direct patient/medical provider visit due to the fact that I will not be in the same room as my care provider.
- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue any telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during any consultation and thus will have the right to request the following: (1) omit specific details of my medical visit that are personally sensitive to me; (2) ask medical personnel to leave the telehealth room; and/or (3) terminate the consultation at any time.
- The alternatives to telehealth care will be explained to me, and I may choose to participate in telehealth or an alternative.
- In an emergent need, I understand that the responsibility of the telehealth Provider is to advise my local practitioner and that coordination will occur between the telehealth Provider and a Provider on-site.
- I understand that in the event I am not able to access a HIPAA compliant platform and choose to engage in a telehealth visit utilizing another platform such as FaceTime, Skype, etc, that I cannot be assured that my personal health information is

completely protected. Due to the COVID-19 state of emergency, I understand that this is an exception to HIPAA security, and I elect to proceed with a telehealth visits in this manner.

- I understand that billing will occur from the SCCC.
- I understand that my insurance may not cover Telehealth services and will be responsible for cost.

I have read this document carefully and understand the risks and benefits of telehealth appointments and have had my questions regarding the procedure explained and I hereby consent to participate in telehealth visits under the terms described herein.

E-Mail:

- I understand that I can choose for SCCC to contact me via email, with an email address that I provide or any email that I communicate from to SCCC.
- I understand that SCCC offers a patient portal which is secure and encrypted. In the portal I can access portions of my medical record. This is a recommended source of secure communication. Open email exchanges should be limited to communication that does not contain sensitive patient information. Email is not appropriate for urgent or emergenty communication.
- I authorize SCCC to notify me of appoinments by email reminder, to share information about SCCC programs and services offered in the community, including programs specific to me. I may also receive patient surveys or information about SCCC news and events.
- I may "opt out" of this service and can call 970-668-4040 to do so. I understand it can take up to 10 business days to process my request and that already scheduled messages may still be received to my email account during this time..
- If my email address changes I will promptly notify SCCC by calling 970-668-4040.
- It is important to understand that email is typically considered unsecure unless fully encrypted, requiring the use of strong authentication and password protection. Most email does not meet this standard. Risks of using email to communicate sensitive medical info include:
  - Email can be forwarded, printed, and stored in paper and electonic form. It can be received by intended and unintended recipients without my knowledge or consent.
  - Emails may be sent to the wrong adress by sender or receiver.
  - Email is easier to forge.
  - Copies of emails may exist after it is deleted by sender or receiver.
  - Email service providers have a right to archive and inspect emails sent through their systems.
  - Email can be intercepted, altered, forwarded, or used without detection or authorization.
  - Email can spread computer viruses.
  - Email delivery is not guaranteed.
  - Email can be used for Phishing. Phishing is a technique of obtaining sensitive personal informaiton from individuals by pretending to be a trusted sender.
  - The use of open internet email channels is not secure or encrypted- meaning that message between sender/ receiver can be potentially viewed by unauthorized persons who might intercept and/ or read those emails.
  - SCCC and its providers may not monitor my emails or may not even receive them. If I feel there is an undue delay in response to an email I send, it is my responsiblity to follow up.

  SCCC will never ask for personal identifying information or other sensitive information using open email. Such information might include name, date of birth, mother's maiden name, social security numbers, or other personal identifying information.

Text Messaging

I authorize SCCC through its vendor RavePoint to contact me by SMS text message to serve me better. SCCC may send text messages to me for things such as:

- Appointment Reminder
- Notice if I am overdue on routine care
- Patient satisfaction surveys
- Other general information

I am under no obligation to authroize SCCC to send me text messages. I may opt out at any time by calling 970-668-4040. I understand that message / data rates may apply to messages sent from SCCC to my cell phone and I could receive up to 10 texts per month.

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Policy For Patients Who "No-show" For Appointments

It is important to us to have an appointment available for you when you need one, and to see you as close as possible to the scheduled time of your appointment. When patients fail to appear for appointments, other patients lose the opportunity to utilize that appointment time, which compromises appointment availability. When patients arrive late for appointments, it becomes difficult to see all patients on time, which inconveniences other patients and staff members.

To best serve all our patients, we want to stress the importance of keeping scheduled appointments and arriving on time. If you realize that you will not be able to arrive on time for a scheduled appointment, please contact us as soon as possible. This allows us to find another appointment time for you, and to offer your original appointment time to another patient in need.

Please read the "no-show" policy below to help us continue our commitment to quality, timely care.

1. A "no-show" is defined as failure to appear on time for a scheduled appointment at the SCCC or failure to cancel the appointment more than 24 HOURS before a medical or behavioral health appointment and 2 hours before a dental appointment is scheduled to begin.
2. After the second "no-show" in a 6-month period, a patient can no longer schedule appointments ahead of time, and can only access care on a "walk-in" basis.
3. "Walk-in" appointments can be made only in person (you will not be allowed to schedule an appointment over the phone) for the same day (you cannot come in person to schedule an appointment for a future date).
4. If patient no shows to the walk-in appointment, patient will then have to walk in and stay in the clinic until appointment time.
5. After you have been seen on a "walk-in" basis one time, you can again schedule appointments ahead of time by phone. However, if you have another "no-show" within 6 months, you will again lose access to appointment scheduling, and your next appointment will be "walk-in" only.

FINANCIAL AGREEMENT

As a patient, your responsibility is paying for services SCCC provides to you to the extent of your ability. SCCC offers various discount programs to patients. Certain discount programs are only available by completing an application. If you are interested in applying for discounted services, contact our Eligibility staff at 970-668-6681.

If you have health or dental insurance, it is important for you to understand the terms of your policy. Your policy is a contract between you and your insurance carrier. You are responsible for knowing which facilities (clinic, hospital, dental office, labs, etc.) and providers (physicians, dentists, etc.) are participating with your insurance carrier.

ParticipatingInsurances: Valid health insurance information must be provided to SCCC to ensure appropriate payment for your care. **In order to bill your insurance, you must provide SCCC with a copy of your current insurance cards along with identification to verify coverage**. We participate with most of the local plans offered. You may inquire if we participate with your specific insurance. If your insurance does not pay 100%, you will be responsible for any deductible, co-payment, coinsurance, and any non-covered services. If SCCC participates with your insurance, SCCC will submit your claim to your insurance(s) for you. We will bill you for any charges that your insurance does not cover (patient responsibility). You may be eligible for discounts on your patient responsibility if you have applied as described above. If we can determine your patient responsibility at the time of service, we will collect that amount at the time of service. If your insurance does not pay within 120 days, we may bill you for the services or ask you to contact your insurance company.

Non-Participating Insurances: Valid health insurance and identification is still required in order for SCCC to determine if your insurance is "out-of-network." If SCCC does not participate with your insurance, you will be responsible for the full charges at the time of service. Discounts may be applied if you have applied as described above. We will provide you with a bill for you to file your claim with your insurance plan. SCCC does not participate with any Workers' Compensation or Auto Insurance plans.

Self-Pay: If you do not have insurance, you will be responsible for paying the amount due after any discounts have been applied. If you receive discounts, most services are included in the discounted fee. However, there are certain labs, supplies, medications, and other services that are charged in addition to the discounted fee. These additional charges, if any, must be paid in full the day of service.

Certain services require pre-authorization from your insurance in order to be covered. In these cases, we must receive the pre-authorization from your insurance before you receive the services. Failure to get the pre-authorization will make the services non-covered. If the services are not covered, you will be responsible for the full amount after any applicable discounts.

SCCC will usually bill you monthly for all unpaid amounts that are your responsibility. If you are not able to pay the balance due, SCCC offers a payment plan, for which you must sign a payment agreement. If you believe your situation deserves special attention, please inquire with SCCC staff. Failure to pay for your services may make you ineligible to receive future services at SCCC. If you have any questions, please contact our Billing team at 970-423-8837.

I have read and understand the contents of this notice and have provided current and accurate information. I authorize SCCC to bill my insurance, act as my designee with my insurance and collect the benefits from my insurance for my services. I authorize the release of my personal, medical, behavioral health and dental information for the purpose of billing my insurance company or other billing and collection purposes. I assign directly to SCCC all medical, behavioral health and dental benefits otherwise payable to me for services provided to me. I agree to pay for services not covered by my insurance including any coinsurance and deductibles. If I do not have insurance coverage, I agree to pay the appropriate discounted fees for the services provided to me.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATON. PLEASE REVIEW IT CAREFULLY.

Your health information is personal, and SCCC is committed to protecting it. Your health information is also an important part of our ability to provide you with quality care, and to comply with certain laws. These privacy practices are in compliance with HIPAA and HITECH regulations, which pertain to the use of private health information in written, oral and electronic formats. These privacy practices will serve as authority to access and share your health information as outlined by the terms of this notice as used by SCCC to provide you with the best health care possible.

I. Understanding Your Health Information

Each time you visit SCCC, an electronic record of your visit is created. This record usually contains your name and other information that may identify you, your symptoms, examination and test results, diagnoses, medications, treatment, plan for future health care, and financial information. This record is sometimes referred to as your "health record" and allows: Medical, dental and behavioral health providers to plan your treatment; SCCC to obtain payment for services we provide to you; and SCCC to measure the quality of care provided to you. We are committed to keeping your health information confidential. We will not use, or give to others, your health information without your written permission, except as stated in this notice.

II. How We Will Use and Give Out Your Health Information

a. Treatment, Payment, and Health Care Operations

We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our community health center. For example: We will give your health information, in verbal, written or electronic formats, to health care professionals, not on our staff, such as other doctors, pharmacies and hospital staff, who help care for you; we may bill you or a third party for services; we may use your health record to review our performance and make sure you receive quality health care.

b. Other Uses and Disclosures Allowed or Required by Law

Additional Uses and Disclosures that DO NOT Require Your Written Authorization: Public health activities, disclosures about victims of abuse, neglect or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, information about deceased persons, organ, eye or tissue donation purposes, research purposes, to avert a serious threat to health or safety, specialized government functions, workers' compensation and when required by law.

c. Other Uses and Disclosures Requiring Your Written Permission

For some types of health information, there may be stricter restrictions on our use or disclosure. For example, drug and alcohol abuse patient treatment information, HIV test results, mental health information, and genetic testing results may be subject to greater protection of your privacy. In general, we may disclose a minor patient's health information to a parent or guardian, but we may deny the parents' access to the minor patient's health information in some situations which are bound by stricter privacy laws.

Except as stated above, we will use or give out your health information only after getting your written permission on an Authorization/Records Request Form. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

III. Your Rights Regarding Your Health Information

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including the rights to: Request limits on uses of your health information, receive confidential communications of your health information, inspect and copy your health information, request a change to your health information, receive a record of how we have used and given out your health information, obtain a paper copy of this Notice of Privacy Practices

IV. CORHIO and Health Information Exchange

As a patient of SCCC, your health information is automatically entered into an electronic exchange that is accessible by other health care providers. This results in better care because other providers can see your health history and treat you more effectively. You have the choice to opt-out of the electronic exchange, and also have the option of opting-in again if you change your mind. Please see the front desk staff for more information. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Questions, Concerns, and Changes to this Notice

If you have any questions or want to talk about any of the information in this Notice of Privacy Practices, please contact the Privacy Officer at the SCCC at 970-668-4040.

If you believe your privacy rights have been violated, you may file a complaint with SCCC, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **We will not retaliate against you for filing a complaint.**

We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by posting the changed notice at SCCC and on our website.