PATIENT INFORMATION

Patient's Last Name: First Name: Middle Initial:	Birth Date:	Sex at birth: ❑ M ❑ F	Marital status (circle one) ❑ Single ❑Married

Social Security no.:	Are you a Veteran: ❑ Y ❑ N	Do you have insurance: ❑ Y ❑ N ❑ Medicare ❑ Medicaid ❑ Private	Email:
Physical address:	City:	State:	Zip Code:
Mailing address (if different):	City:	State:	ZIP Code:

Home phone no.:	Cell Phone No.:
Can we leave detailed messages: ❑ Y ❑ N If yes, what phone number?	Will you like to receive APPOINTMENT reminders via text message? ❑ Y ❑ N
Pharmacy Name, City, State and Zip Code:	Employer Name and Address and phone no.:
Parent or Guardian name and Date of Birth, if patient is under 18:	

Family Gross Income $______________________ Week / Every 2 weeks / Month / Year

Number of people living in the same household supported by this income (Including yourself) _________

PLEASE CIRCLE:

RACE (CIRCLE AT LEAST ONE)		PRIMARY LANGUAGE (CIRCLE AT LEAST ONE)	ETHNICITY (CIRCLE ONE)
BLACK OR AFRICAN AMERICAN		AMERICAN SIGN LANGUAGE	HISPANIC ORIGIN
AMERICAN INDIAN OR ALASKA NATIVE		ENGLISH	NOT HISPANIC ORIGIN
ASIAN		FRENCH	NOT PROVIDED
WHITE		POLISH	
NATIVE HAWAIIAN	OTHER PACIFIC ISLANDER	RUSSIAN	
NOT PROVIDED		SPANISH	

PLEASE CIRCLE:

GENDER IDENTITY (CIRCLE ONE)		SEXUAL ORIENTATION (CIRCLE ONE)	
MALE	FEMALE	HETEROSEXUAL(NOT LESBIAN OR HOMOSEXUAL)	
TRANSGENDER FEMALE/MALE TO FEMALE		LESBIAN OR HOMESEXUAL	
TRANSGENDER MALE/FEMALE TO MALE		BISEXUAL	SOMETHING ELSE
CHOOSE NOT TO DISCLOSE	OTHER	DO NOT KNOW	CHOOSE NOT TO DISCLOSE

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 ambulance 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 # _____________________

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.

I agree to notify Summit Community Care Clinic promptly of any change in household members, address, phone, income, insurance or other essential information. I understand that I must show my card at time of service.

I understand that I am responsible for any charges for service and I agree to pay for services at the time of service. I hereby consent to all treatment which the medical staff of Summit Community Care Clinic determines to be necessary

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

Your Name: _______________________________ ***Relationship:*** ____________________

X X

Applicant Signature **Date**

FOR STAFF USE ONLY

SYSC TITLE X FULL FEE

ANNUAL INCOME $ ___________________

FEE CODE __________ HH ____________

TEMP PRENATAL CC

ANNUAL INCOME $ ___________________

FEE CODE __________ HH ________

EXPIRATION _____ /_____ /_____

Limited English Proficiency? YES NO

INITIALS _______

DATE _______ /_______ /_______

Summit Community Care Clinic Treatment Consent

I, ________________________________, do hereby give my consent to the medical staff at Summit Community Care Clinic to examine, treat and counsel me.

I understand and agree with the following:

- 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 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 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 agree to a physical exam, if one is recommended.
- I understand that my provider might 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 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.
- 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.

I have read the above information. It has been explained to me and I believe I understand it. My questions have been answered by a person from the Summit Community Care Clinic.

____

Signature of client Date Time

____

Signature of witness Date Time

FINANCIAL AGREEMENT

Summit Community Care Clinic (SCCC) is committed to providing you the best possible care. 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. The discount programs are generally only available by completing an application. If you are interested in applying for discounted services, contact our Eligibility staff at 970-668-6681.

SCCC participates with Medicare, Colorado Medicaid and various insurance companies. All these are referred to below as insurance. SCCC does not participate will all insurance companies.

If SCCC participates with your insurance, SCCC will submit your claim to your insurance 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. ***You must provide us a copy of your current and valid insurance card, along with a current identification to verify coverage.***

If SCCC does not participate with your insurance, discounted charges (if you have applied for discounts) or charges at standard rates are to be paid in full at the time service is rendered. We will provide you with a bill for you to file your claim with your own insurance.

Certain services, especially certain dental 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 may make the services non-covered. If the services are not covered, you will be responsible for the full or discounted amount.

If you do not have insurance, you will be responsible for paying the discounted amount (if you have applied for discounts) or charges at standard rates at the time of service. If you receive discounts, most services are included in the discounted fee. However there are certain labs, supplies 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.

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.

Print Patient Name____ **Date of Birth** ___________________

Insurance Company and number______________________________________ **Insurance ID** _______________
Please note Medicare, Medicaid, name of Private Insurance policy or write “none”

Name of Policy Holder ____**DOB of Policy Holder** _____________
Please print your name if other than the patient. Also note your relationship to the patient.

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 and dental information for the purpose of billing my insurance company or other billing and collection purposes. I assign directly to SCCC all medical 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 charges for my services.

Patient or Responsible Person Signature______________________________________ **Date**_____________
Form effective 7/1/15

SUMMIT COMMUNITY CARE CLINIC-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. Effective Date: 7-29-14

Your health information is personal, and Summit Community Care Clinic 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 Summit Community Care Clinic to provide you with the best health care possible.

I. Understanding Your Health Information

Each time you visit Summit Community Care Clinic, 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; Summit Community Care Clinic to obtain payment for services we provide to you; and Summit Community Care Clinic 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 Summit Community Care Clinic at 668-4040.

If you believe your privacy rights have been violated, you may file a complaint with Summit Community Care Clinic, 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 Summit Community Care Clinic and on our website.

I have received, read, and understand the Summit Community Care Clinic Notice of Privacy Practices

Patient Name: ____

Patient Signature:____ **Date:**____________________

Policy For Patients Who "No-show" For Appointments

Welcome to the Summit Community Care Clinic. 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 or at least 2 hours prior to appointment**. 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 Summit Community Care Clinic or failure to cancel the appointment more than **2 HOURS** before it 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.

Patient Name: ____________________________________ DOB ____________

Signature: ____________________________________ Date: ____________