DESERT SENITA
COMMUNITY HEALTH CENTER
Quality, Local, Affordable Health Care for All

Patient Registration Form

Patient Information: *Last Name* _____ *First Name* _____ *Social Security No.* _____

Physical Address _____ *City* _____ *State* _____ *Zip* _____ *County* _____

Mailing Address _____ *City* _____ *State* _____ *Zip* _____ *County* _____

Home Phone _____ *Work Phone* _____ *Email Address* _____ *Date of Birth* _____

Household Size _____ **Head of Household Name** _____ **Income Level** ☐ Monthly ☐ Annual

Primary Insurance _____ **ID #** _____ **Group #** _____ **Name of Insured Party** _____

Responsible Party: *Last Name* _____ *First Name* _____ *Social Security No.* _____

Physical Address _____ *City* _____ *State* _____ *Zip* _____ *County* _____

Mailing Address _____ *City* _____ *State* _____ *Zip* _____ *County* _____

Home Phone _____ *Work Phone* _____ *Email Address* _____ *Date of Birth* _____

Employer Name _____ *Employer Address* _____

Relationship to Responsible Party

☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Marital Status

☐ Single ☐ Married ☐ Divorced

Primary Language

Race

☐ Asian
☐ American Indian/Alaska Native
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ White

Are you Hispanic/Latino? ☐ YES ☐ NO

Are you a veteran? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO

Some of the following questions may be uncomfortable for you to answer; however, your honest responses will assist Desert Senita in providing the best services for you as an individual. By answering the following questions, you will help us to qualify the resources that support the services we provide for you.

Sexual Orientation:
☐ Lesbian/Gay/Homosexual
☐ Straight/Heterosexual
☐ Bisexual
☐ Something Else/Other
☐ Don't Know/Questioning
☐ Choose Not To Disclose

Gender Identity:
☐ Male
☐ Female
☐ Other/Gender Variant/Inter-sex
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Choose Not To Disclose

Sex Assigned At Birth:
☐ Male
☐ Female
☐ Choose Not To Disclose

What pronoun do you prefer to be addressed by? ☐ She/Her ☐ He/Him ☐ They ☐ Zie/Hir ☐ Other: _____

Emergency Contact: *Name* _____ *Relationship* _____ *Home Phone* _____ *Work Phone* _____

AUTHORIZATION AND ASSIGNMENT

I voluntarily consent to outpatient care with Desert Senita Community Health Center and/or Dental Center (DSCHC/DSDC), encompassing routine, minor surgical, diagnostic and/or dental procedures. I understand the insurance company I have listed above will be billed for my services. I assign claim payments from the insurance company to be made payable to DSCHC and/or DSDC. I understand that all services may not be covered and I will be financially responsible for balances not covered by my insurance. I understand that any overpayment on my account will be refunded in a timely manner. The attending provider (Doctor, Certified Physician's Assistant, Advanced Registered Nurse Practitioner or Dentist) may disclose any necessary information to Medicare, Medicaid and any third party payer. This authorization and assignment may be revoked by me at any time by written notice.

._____

_____

Signature **Date**

Desert Senita Community Health Center
Dental Patient Registration Form

No Cavity Club for Children

If your child does not have cavities at their checkup appointment, we take their picture for our "No Cavity Club" and post the picture on the bulletin board. Do we have your permission to do this? ☐ Yes ☐ No

Insurance Information

If you have dental insurance please provide us with a copy of your card. Also be sure to let us know if you have a secondary insurance as well.

Dental History

Reason for Today's Visit: _____
Previous Dentist: _____ Date of Last Visit: _____
Do you floss daily: ☐ Yes ☐ No Do you brush daily: ☐ Yes ☐ No
Are you in pain: ☐ Yes ☐ No Are you happy with your smile ☐ Yes ☐ No: _____

Please check yes or no to indicate if you have or have had any of the following:

Bleeding gums:	**☐ Yes ☐ No**	**Mouth breathing:**	**☐ Yes ☐ No**
Biting of the cheek or lips:	**☐ Yes ☐ No**	**Orthodontics/Braces:**	**☐ Yes ☐ No**
Blisters on lips or mouth:	**☐ Yes ☐ No**	**Pain around ear:**	**☐ Yes ☐ No**
Burning sensation on tongue	**☐ Yes ☐ No**	**Sensitivity to cold:**	**☐ Yes ☐ No**
Cigarette, pipe, or cigar smoking	**☐ Yes ☐ No**	**Sensitivity to hot:**	**☐ Yes ☐ No**
Clicking jaw or jaw pain:	**☐ Yes ☐ No**	**Sensitivity to pressure:**	**☐ Yes ☐ No**
Dry mouth:	**☐ Yes ☐ No**	**Sensitivity to sweets:**	**☐ Yes ☐ No**
Fingernail biting:	**☐ Yes ☐ No**	**Sores or growths in mouth:**	**☐ Yes ☐ No**
Food collection in teeth:	**☐ Yes ☐ No**	**Swollen or tender gums:**	**☐ Yes ☐ No**

Medical History

Primary Physician's Name: _____ Date of Last Visit: _____
Phone: (____) _____-_____ Pharmacy: _____ Phone: (____) _____-_____
Please check yes or no to indicate if you have or have had any of the following:

AIDS/HIV: ☐ Yes ☐ No
Arthritis: ☐ Yes ☐ No If yes, type? _____
Artificial Joints ☐ Yes ☐ No If yes, where? _____
Asthma: ☐ Yes ☐ No If yes, when was the last attack? _____
Back Problems: ☐ Yes ☐ No
Bleeding Abnormally with Extractions or Surgery: ☐ Yes ☐ No
Blood Disease: ☐ Yes ☐ No If yes, type_____
Cancer: ☐ Yes ☐ No If yes, type? _____
Chemical Dependency: ☐ Yes ☐ No
☐ Alcohol ☐ Marijuana
☐ Cocaine ☐ Methamphetamines
☐ Heroine ☐ LSD
Chemotherapy: ☐ Yes ☐ No
Colitis: ☐ Yes ☐ No
Cortisone Treatments: ☐ Yes ☐ No
Cough, Persistent or Bloody: ☐ Yes ☐ No
Diabetes: ☐ Yes ☐ No
Emphysema: ☐ Yes ☐ No
Epilepsy: ☐ Yes ☐ No
Fainting or Dizziness: ☐ Yes ☐ No
Glaucoma: ☐ Yes ☐ No
Headaches: ☐ Yes ☐ No If yes, frequency? _____
Heart Problems: ☐ Yes ☐ No
☐ Artificial Heart Valves: _____ ☐ High Blood Pressure
☐ Congenital Heart Lesions
☐ History of Infective Endocarditis ☐ Pacemaker
Hepatitis ☐ Yes ☐ No If yes, type? _____
Kidney Problems: ☐ Yes ☐ No If yes, dialysis? _____ Days? _____
Liver Problems: ☐ Yes ☐ No
Lupus: ☐ Yes ☐ No
Nervous Problems: ☐ Yes ☐ No If yes, type? _____
Osteoporosis: ☐ Yes ☐ No
Prostate Problems: ☐ Yes ☐ No
Psychiatric Care: ☐ Yes ☐ No If yes, type? _____
Radiation Treatment ☐ Yes ☐ No If yes, where? _____
Respiratory Disease: ☐ Yes ☐ No If yes, type? _____

Desert Senita Community Health Center
Dental Patient Registration Form

Rheumatic Fever: ☐ Yes ☐ No
Shortness of Breath: ☐ Yes ☐ No **If yes, due to** _____
Sickle Cell Disease/Traits: ☐ Yes ☐ No
Sinus Trouble: ☐ Yes ☐ No

STD: ☐ Yes ☐ No
- ☐ Herpes
- ☐ HPV
- ☐ Syphilis

Stroke: ☐ Yes ☐ No
Swollen Feet or Ankles: ☐ Yes ☐ No
Thyroid Problems: ☐ Yes ☐ No
Tumors or Growths: ☐ Yes ☐ No
Tuberculosis: ☐ Yes ☐ No
Ulcer: ☐ Yes ☐ No

Are you currently under the care of a physician? If so, why?
_____

Do you need to be pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No

Do you have any other medical conditions not listed above? If yes please explain:
_____

Please List Any Medications You Are Taking:
_____

Have you ever taken any of the following medications:
Blood Thinners: ☐ Yes ☐ No **Osteoporosis Medications:** ☐ Yes ☐ No
Coumadin/Wafarin: ☐ Yes ☐ No ☐ Actonel ☐ Fosamax
Diet Medications: ☐ Yes ☐ No ☐ Aredia ☐ Zometa
Levoxyl: ☐ Yes ☐ No ☐ Boniva
Synthroid: ☐ Yes ☐ No
Are you allergic to any of the following:
Antibiotics: ☐ Yes ☐ No **If yes, which?** _____
Aspirin: ☐ Yes ☐ No **Local Anesthetic:** ☐ Yes ☐ No
Codeine: ☐ Yes ☐ No **Metals:** ☐ Yes ☐ No **If yes, which?** _____
Ibuprofen: ☐ Yes ☐ No **Sulfa:** ☐ Yes ☐ No
Latex: ☐ Yes ☐ No

Do you have any other allergies? ☐ Yes ☐ No **If yes, to what?**_____**Reaction?**_____
Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____
Have you ever been hospitalized or do you have any health concerns? ☐ Yes ☐ No
If yes, please explain: _____
Do we have your permission to discuss your medical history with you? ☐ Yes ☐ No
Would you like to speak with the doctor in private? ☐ Yes ☐ No
Women only
Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
If yes, which trimester? _____**2**
Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

To the best of my knowledge, this information is complete and correct. I understand the insurance company I have listed above will be billed for services rendered in this office and all benefits from the insurance company will be assigned to Desert Senita Dental Center. The attending dentist may disclose any necessary health information to my insurance company for payment. I understand all services may not be covered and I will be financially responsible for any balance not covered by my insurance company. Should I not have insurance coverage, or the funds to pay for the recommended services, it is my responsibility to make payment arrangements with the patient financial coordinators.

Signature: _____ **Date:** _____/_____/_____
Name of person filling out form if not patient: _____
Relationship to Patient: _____
Dentist's Signature: _____ **Date:** _____/_____/____

Desert Senita Community Health Center
Dental Patient Registration Form

No Show Policy

Access to care:
In order to assist patients seeking treatment access to the dental office, patients who "NO SHOW" three (3) times within six (6) months will be unable to schedule appointments unless approved by the dental director.

Chronic "NO SHOW" patients:
Chronic "NO SHOW" patients will be notified when they are able to once again make appointments. Should the chronic "NO SHOW" patients have pain, they may come for an evaluation of the condition causing pain; however, no scheduled appointment may be made due to their repeated "NO SHOW" behavior.

Cancellations:
Patients who cancel 24 hour before their scheduled appointment are exempt from the policy penalty.

Questions and/or comments:
Should patients have any questions and/or comments, they should address the dental director in writing. Please specify the issue and any extenuating circumstances for consideration of variation from this policy. The dental director and his/her designee shall make a decision and reply in writing within ten (10) days after receipt or the "Request for consideration of variation of policy" from the patient.

Patient name (printed): _____

Patient (or guardian) signature: _____

Date: _____

Desert Senita Community Health Center
Dental Patient Registration Form

Patient Rights & Responsibilities

As a patient, you have the right:

- To be treated with respect, including recognition of personal beliefs and values.
- To receive care in a setting and environment committed to patient safety.
- To privacy and confidentiality.
- To coordination and continuity of your health care.
- To know the identity of providers, nurses and others involved in your care.
- To information presented in terms you can understand, including treatment and care options.
- To be involved in decisions regarding your health care plan.
- To reasonable access to health care.
- To access health care records according to the Desert Senita Community Health Center's policy and procedure.
- To be heard if problems, complaints or grievances arise.
- To be informed of charges for services as well as payment options.
- To change your provider if other qualified providers are available.

As a patient, you have a responsibility:

- To provide complete medical information to your health care providers.
- To ask questions so that you have a clear understanding.
- To make informed decisions.
- To report and changes in your health.
- To understand your health problems and to follow agreed upon plans and instructions for your care.
- To recognize the impact of your lifestyle choices on your personal health.
- To keep scheduled appointments, reschedule in a timely manner or cancel your appointment within 24 hours of appointment time.
- To respect the rights, privacy and confidentiality of other patients and clinic personnel.
- To accept financial obligations and understand your health insurance benefits.
- To inform your provider about any living will, medical power of attorney or other directive that could affect your care.
- To be photographed one time and have that photo placed in your chart for identification purposes OR:
- To be prepared to show photo identification at each visit for patients 18 years or older.

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Patient signature **Date**

Your signature indicates you have received a copy of your rights/responsibilities

Desert Senita Community Health Center
Dental Patient Registration Form

Informed Consent for Dental X-rays

Benefits:

- More complete diagnosis
- Can find hidden problems
- Can make a determination of treatment
- X-rays taken by qualified personnel

Complications (including but not limited to the following):

- Exposure to x-ray radiation (minimal)

Consequences of not performing treatment:

- Cannot perform dental services

Alternatives:

- None

I certify that I have read and fully understand the above document and have had the opportunity to ask any questions and give my consent to the above recommended treatment.

Patient Name:_____ Date:_____

Patient Signature or legal guardian:_____

Dentist Signature: _____

Desert Senita Community Health Center
Dental Patient Registration Form

Informed Consent for Prophy (cleaning) and/or Fluoride (rinse or varnish)

This is an informed consent form for _____ to receive dental treatment, which may include cleaning (prophy), fluoride. If needed, an anesthetic may be used for pain control (such as Oraqix or local anesthetic). Also, subgingival irrigation may be performed with either 0.12% chlorhexidine gluconate and/or tetracycline diluted in distilled water.

Benefits:

- Fresher breath
- Stronger teeth/cavity prevention
- Removal of plaque and bacteria (soft food deposits)
- Removal of calculus (hard food deposits)

Risks:

- Possible pain
- nausea
- bleeding
- infection
- swallowing of foreign matter, saliva
- possible allergic/anaphylactic reaction

Alternatives:

- none

By signing below you acknowledge that you have read this document, understand the information presented, give consent to the above treatment(s) and have had all your questions answered satisfactorily.

Patient Name: _____ Date: _____

Patient Signature (parent or legal guardian): _____

Desert Senita Community Health Center
Dental Patient Registration Form

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____,
(Patient Printed/Guardian Name)

have received the Notice of Privacy Practices from
Desert Senita Community Health Center.

X_____Date_____
(Patient/Guardian Signature)

OR

In lieu of patient signature, I, _____,
(Printed Employee Name)

employee of Desert Senita Community Health Center, state that

_____
(Printed Patient/Guardian Name)

has been given a current Notice Of Privacy Practices.

X_____Date_____
(Employee Signature)

Desert Senita Community Health Center
Dental Patient Registration Form

PRIVACY NOTICE Desert Senita Community Health Center

(THIS NOTICE DESCRIBES HOW MEDICAL, DENTAL, AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.) Effective date September 23, 2013 (Revised May 1, 2014)
PLEASE REVIEW CAREFULLY

WHO WILL FOLLOW THIS NOTICE
This notice describes the practices of Desert Senita Community Health Center (DSCHC) regarding the use of your health information and that of:

- any of our healthcare professionals authorized to enter information into your medical, dental or behavioral health record
- all departments and units of Desert Senita Community Health Center, any member of a volunteer/student group we allow to help you while you are in our facility
- all employees, contracted staff and other DSCHC personnel
- all affiliates, sites and locations of the Desert Senita Community Health Center will follow the terms of this notice. In addition, these affiliates, sites and
- locations may share health information with each other for the treatment, payment or health care purposes described in this notice.

OUR PLEDGE REGARDING YOUR HEALTH CARE INFORMATION
We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated at Desert Senita Community Health Center whether made by health care professionals or other personnel.

This notice will tell you about the ways in which we may use and disclose healthcare information about you. Disclosure, as appropriate, may be verbal communication, electronic transmission, paper record, or by fax. We also describe your rights and certain obligations we have regarding the use and disclosure of healthcare information.

We are required by law to:

- Keep personal healthcare information private;
- Give you this notice of our legal duties and privacy practices with respect to your healthcare information; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTHCARE INFORMATION ABOUT YOU
The following are examples of the types of permitted uses and disclosures of your protected healthcare information. These examples are not meant to be all inclusive, but rather to describe the types of uses and disclosures that may be made by our office once you have provided consent.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

- **For Treatment** Information obtained by a nurse, provider, or other member of your healthcare team will be recorded in your healthcare record and used to determine the course of treatment that should work best for you. We may disclose your health information to others who will need this information in order to treat you, for example another DSCHC provider, nurse practitioners, pharmacists, or others involved in your care. We may also disclose your protected health information to another healthcare provider (e.g., a specialist or laboratory) who, at the request of your DSCHC provider, becomes involved in your care by providing assistance with our healthcare diagnosis or treatment.
- **For Payment** We may use and disclose your protected health information for billing and collection purposes. For example, we may need to give your 3rd party payor/Health Plan information about your care so that they will pay us or reimburse you for this care. We may also provide information to your Health Plan or 3rd party payer about a treatment/service that has been ordered by your healthcare provider in order to obtain prior approval or to determine whether your plan will cover the treatment/service.
- **For Healthcare Operations.** We may use or disclose, as needed, your personal health information in order to support our business activities. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.
- **Other examples of healthcare operations might include:**
    - Use of a sign-in sheet at the front desk where you will be asked to sign your name.
    - Calling you by name in the waiting room when your healthcare provider is ready to see you.
    - We may contact you (by telephone or mail) to remind you about your appointment.

Desert Senita Community Health Center
Dental Patient Registration Form

We will share your personal health information with 3rd party "business associates" that perform various activities for DSCHC. Whenever an arrangement between our office and a business associate involves the use or disclosure of your personal health information, we will have a written contract that contains terms that will protect the privacy of your health information. Some examples of our business associates would include X-ray interpretation services, contracted laboratory testing, medical transcription services, record copy service and record storage facilities.

II. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT. We may use and disclose your personal health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your personal health information.

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object in advance, we may release protected health information about you to a friend or family member who is involved in your medical care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may also give information to someone who helps pay for your care. In addition, we may disclose personal health information about you to an authorized entity assisting with disaster relief efforts. We may allow family or friends to act on your behalf to pick up filled prescriptions, medical supplies, x-rays, and similar forms of personal health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.
- **Emergencies.** We may use or disclose your protected health information in an emergency treatment situation should you be unable to consent prior to treatment. If this happens, we shall try to obtain your consent as soon as reasonably practicable after the treatment. If we are required by law to treat you and are unable to obtain your consent, we may still use or disclose your protected health information to treat you.
- **Treatment Alternatives.** We may use or disclose your personal health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services, that are available from DSCHC, that may be of interest to you. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.
- **Fundraising Activities.** We may use or disclose your demographic information in order to contact you for fundraising activities supported by our clinic. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

III. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT.

- **As Required By Law.** We will disclose your personal health information when required to do so by federal, state or local law.
- **Research.** We may disclose your personal health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your personal health information. For example, we may conduct a research project involving the review of healthcare records for all patients with specific types of medical conditions.
- **Public Health Risks.** We may disclose your personal health information for public health activities. These activities generally include the following:
    - To prevent or control disease, injury or disability
    - To report deaths
    - To report child abuse or neglect
    - To report reactions to medications or problems with products
    - To notify people about recalls of products they may be using
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
    - To notify the appropriate authority if we believe a patient has been the victim of abuse, neglect or domestic violence
- **Worker's Compensation.** We may release your personal health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Coroners, Funeral Directors, and Organ Donation.** We may release your personal health information to a coroner or medical examiner to assist with identifying the deceased or determining the cause of death. We may release your personal health information to a funeral director as necessary to carry out their duties. If you are an organ donor, we may release your personal health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- **Military and Veterans.** If you are a member of the armed forces, we may release your personal medical information as required by military command authorities.

- **Health Oversight Activities.** We may disclose your personal health information to a health oversight agency for activities authorized by law. Examples of oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Legal Proceedings.** We may release your personal health information in response to a subpoena, discovery request, or other lawful orders from a court or administrative tribunal (to the extent such disclosure is expressly authorized).
- **Law Enforcement.** We may release your health information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or whenever required to do so by law.
- **Inmate.** We may use or disclose your personal health information if you are an inmate of a correctional facility and your healthcare provider created or received your personal health information in the course of providing care to you.
- **Protected Services for the President, National Security and Intelligence Activities.** We may release your personal health information to authorized federal officials so they may provide protection to the President, other authorized persons of foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

IV. USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION. Other uses and disclosures of your personal health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose your personal health information, you may revoke this authorization, at any time, in writing. If you revoke your permission, thereafter we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

Authorization is required for: most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU
Although your healthcare record is the physical property of the Desert Senita Community Health Center, the information belongs to you. You have the following rights regarding the healthcare information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of healthcare information that may be used to make decisions about your care. Usually, this includes medical, dental, prescription, and billing records, but does not include psychotherapy notes.
  To inspect and obtain a copy of healthcare information that may be used to make decisions about you, you must submit a written request to our Medical Records Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and obtain a copy in certain very limited circumstances. It you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Desert Senita Community Health Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** It you feel that the 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 for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us;
  - Is not part of the medical information kept by the Desert Senita Community Health Center;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of health information about you. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. 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.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the personal health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the personal health information we disclose about you to someone who is involved in your care or the

payment for your care, like a family member or friend. We are not required to agree to your request, with one exception*. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer at the address below. In your request, you must tell us:

- What information you want to limit;
- Whether you want to limit our use of your information, disclosure to outside entities or both; and
- To whom you want the limits to apply.

* Exception: When you are paying for a service out of pocket and request we not provide it to the Health Plan, we must comply with the request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
  To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to he contacted.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice at any time. You may request a copy of our most current privacy notice from our Registration Office or from the Privacy Officer.
- **Breach Notification**. A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information (PHI) such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual. If a breach occurs, you will be notified the Breach occurred no later than 60 days after the occurrence.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain the effective date at the top of the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Desert Senita Community Health Center or with the Secretary of the Department of Health and Human Services toll free at 1-877-696-6775. To file a complaint with the Desert Senita Community Health Center, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions about this notice, please contact:

Quality Improvement Team
Desert Senita Community Health Center
410 Malacate Street
Ajo, Arizona, 85321
(520) 387-5651