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

Patient Registration Packet

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

Physical Address | *City* | *State* | *Zip* | *County*

Mailing Address | *City* | *State* | *Zip* | *County*

Home Phone | Cell *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**

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Patient Registration Packet

Social Security #_____
Patient Name_____ Medical Record #_____
Address_____ Date of Birth_____ M / F_____ Marital Status_____
City_____ State_____ Zip_____ Occupation/Employer_____
Phone #:_____ Work Phone #:_____
Insurance Name: _____ ID#_____Group #_____Phone #:_____

Hospital Admissions and Chronic illnesses:

Year	Illness or Operation	Year	Illness or Operation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus/Td	_____	Hepatitis A	_____	PSA	_____	Dental	_____
Rectal/Stool	_____	TB Skin Test	_____	Colonoscopy	_____	Eye	_____
Influenza (flu)	_____	Hepatitis B	_____	Cholesterol	_____	Other	_____
Pneumonia	_____	Other	_____				

List all medications you are currently taking: *(Please include any over the counter medication, vitamins, or herbal supplements)*

_____
_____
_____

List Allergies:

_____
_____
_____

Medical History: *(Please check all that apply)*

☐ Decreased hearing
☐ Ringing in ear
☐ Ear infections – frequent
☐ Dizzy spells ☐ Fainting spells
☐ Failing vision ☐ Eye pain
☐ Double or blurred vision
☐ Nose bleeds - recurrent
☐ Sinus trouble
☐ Sore throats - frequent
☐ Hoarseness - prolonged
☐ Hay fever / allergies
☐ Pneumonia / pleurisy
☐ Bronchitis / chronic cough
☐ Asthma / Wheezing
☐ Shortness of breath:
☐ On exertion ☐ Lying flat
☐ Chest pain
☐ Heart murmur ☐ Swollen ankles
☐ Irregular pulse ☐ Palpitations
☐ Leg pain - when walking
☐ Varicose veins / phlebitis
☐ Cold numb feet
☐ Loss of appetite
☐ Difficulty swallowing
☐ Heartburn ☐ Peptic ulcer
☐ Abdominal pain - chronic
☐ Gall bladder trouble
☐ Jaundice ☐ Cirrhosis
☐ Diarrhea ☐ Constipation
☐ Diverticulitis ☐ Crohn's / Colitis

☐ Sexually transmitted diseases
☐ AIDS / HIV ☐ Herpes
☐ Weight-loss ☐ Weight-gain
☐ Anemia ☐ Bruise easily
☐ Blood transfusions
☐ Cancer ☐ Chronic fatigue
☐ Diabetes ☐ Thyroid disease
☐ Seizures ☐ Stroke
☐ Tremor / hands shaking
☐ Numbness / tingling sensations
☐ Headaches – frequent
☐ Arthritis / Rheumatism
☐ Back pain – recurrent
☐ Bone fracture / joint injury
☐ Osteoporosis
☐ Foot pain ☐ Gout
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Sleeping or concentration difficulty
☐ Depression ☐ Nervousness
☐ Agitation ☐ Memory loss
☐ Moodiness ☐ Suicidal thoughts
☐ Phobias ☐ Mental illness
☐ Feelings of worthlessness
☐ Rheumatic Fever ☐ Tuberculosis
☐ Chicken Pox ☐ Polio ☐ Mumps
☐ Measles ☐ German measles
☐ Hepatitis A, B, C or other

Urination Problems

☐ Overnight > than twice

☐ Stress incontinence - urine leakage with exercise / movement
☐ Blood in urine ☐ Kidney stones
☐ Urine infections – frequent

Please fill in daily amount

☐ Alcohol _____ ☐ Coffee _____
☐ Smoking _____packs per day ____years
years quit _____
☐ Exercise _____
☐ Street Drugs _____
☐ Tattoos ☐ Piercing
☐ Hair loss ☐ Progressive ☐ Recent

Females - Please complete

Menstrual flow:
☐ Reg ☐ Irreg ☐ Pain / Cramps
Days of flow _____ length of cycle_____
☐ Pain / bleeding during or after sex
Number of pregnancies:
☐ Pregnancies_____ ☐ Abortions _____
☐ Miscarriages_____ ☐ Live births_____
Birth control method:_____
☐ Hot flashes
☐ Menopause onset_____
☐ Date of last PAP test_____
☐ Normal ☐ Abnormal
☐ Breast exam
☐ Self breast exam teaching
Date of last Mammogram_____
☐ Normal ☐ Abnormal

Males - Please complete

☐ Bloody or tarry stools
☐ Hemorrhoids ☐ Hernia
☐ Victim of abuse

☐ More than 8 times / 24 hours
☐ Urgency to urinate - with leakage
☐ Decrease in force / flow - painful

☐ Last testicular exam _____
☐ Self testicular exam teaching
☐ Penile discharge

Family History: Place the relationship of the family member on the line to the right of the medical term.

1. Epilepsy	_____	7. Hay fever	_____	13. Heart disease	_____	19. Cancer(type)	_____
2. Migraine	_____	8. Asthma	_____	14. Stroke	_____	20. Alzheimer's	_____
3. Mental Illness	_____	9. Anemia	_____	15. Hypertension	_____	21. Lupus	_____
4. Glaucoma	_____	10. Bleeds easily	_____	16. Cholesterol	_____	22. Other	_____
5. Diabetes	_____	11. Osteoporosis	_____	17. Alcoholism	_____		
6. Thyroid disease	_____	12. Arthritis	_____	18. Hepatitis	_____		

Please add any additional information that will help your provider with your medical treatment.

_____
_____
_____

Please circle one
Do you have a Living Will? .....YES NO
Would you like information on Living Will? .....YES NO

Provider Signature_____Date_____

Provider Signature_____Date_____

Provider Signature_____Date_____

Patient Signature _____ Date_____

Provider Signature_____Date_____

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)

Patient Rights and Responsibilities

As a patient you have the right to:

- To be treated with respect, dignity, and consideration including the 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 healthcare.
- 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 healthcare.
- To access health care records according to the health center's policy and procedure.
- To be heard if problems, complaints or grievances arise and not be subjected to retaliation.
- To be informed of charges for services as well as payment options.
- To change your provider if other qualified providers are available.
- To not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, or restraint or seclusion (except as allowed in AZDHS Rule R9-10-1012(B).
- To not be subjected to misappropriation of personal and private property by personnel members, employees, volunteers, or students.

As a patient you have the responsibility to:

- To provide complete medical information to your health care providers and report any changes in your health.
- To ask questions so that you have a clear understanding.
- To make informed decisions.
- To understand your health problems and 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.

_____ _____

Patient Signature Date

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

PRIVACY NOTICE

(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.

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:
Desert Senita Community Health Center
Privacy Officer
410 Malacate Street
Ajo, Arizona 85321
(520) 387-5651