Shasta Community Health Center
a californiahealth+ center

P.O. Box 992790, Redding, California 96099-2790
(530) 246-5710

Dear Patient,

Welcome to Shasta Community Health Center (SCHC). We are pleased that you have chosen us for your primary care medical home. Our mission is to offer quality health care services to everyone. We are a private, non-profit, community health center with sites in Redding, Anderson, and Shasta Lake City. ***Please see a list of our sites and hours on the back of this letter.***

Appointments: We ask that you give at least 24-hours' notice to cancel an appointment. If you are unable to keep your appointment and cannot give 24-hours' notice, please let us know as soon as possible so that we may schedule another person who needs care.

Medications: Please bring all of your medications to every appointment. If you need a refill, please allow up to 5 business days for it to be filled.

Shasta Health Connect: Connecting with your health care team is easier than ever with our online portal, Shasta Health Connect (SHC). Using SHC is easy and saves you time. Whether you want to request an appointment or review your latest test results, SHC delivers the information you need through an easy-to-use, secure website. Go to www.shastahealth.org/hc and follow the instructions to sign up today!

After-Hours Nurse Advice: If you need medical advice after our regular business hours, please call our main center at (530) 246-5710 and listen for the prompt. Our answering service will assist you and, if needed, will connect you to a nurse. In the event of an emergency, call 911.

Thank you for choosing SCHC for your health care needs. We look forward to seeing you and will do our very best to make your visit as pleasant and efficient as possible.

Sincerely,

Shasta Community Health Center

Our Sites and Hours

Shasta Community Health Center

Address: 1035 Placer Street, Redding, CA 96001
Phone: (530) 246-5710
Hours: Monday – Friday, 8 a.m. to 5 p.m.
Urgent Care Extended Hours: Monday – Thursday, 8 a.m. to 8 p.m. / Saturday, 9 a.m. to 1 p.m.

Primary Care Neuropsychiatry (PCN)

Address: 980 Placer Street, Redding, CA 96001
Phone: (530) 246-5916
Hours: Monday – Friday, 8 a.m. to 5 p.m.

Telemedicine / Training Center

Address: 1756 Continental Street, Redding, CA 96001
Phone: (530) 246-5818
Hours: Monday – Friday, 8 a.m. to 5 p.m. (Closed from 12 p.m. to 1 p.m. for lunch)

Women's, Babies' & Children's Center

Address: 1000 Placer Street, Redding, CA 96001
Maternity: (530) 225-7480
Pediatrics: (530) 246-5702
Vision: (530) 229-5101
Hours: Monday – Friday, 8 a.m. to 5 p.m. (Closed from 12 p.m. to 1 p.m. for lunch)

Enterprise Family Health Center

Address: 3270 Churn Creek Road, Redding, CA 96002
Phone: (530) 229-5000
Hours: Monday – Friday, 8 a.m. to 5 p.m. (Closed from 12 p.m. to 1 p.m. for lunch)

Shasta Community Health Dental Center

Address: 1400 Market Street, Suite 8103, Redding, CA 96001
Phone: (530) 247-7253
Hours: Monday – Friday, 8 a.m. to 5 p.m. (Closed from 12 p.m. to 1 p.m. for lunch)

Anderson Family Health & Dental Center

Address: 2965 East Street, Anderson, CA 96007
Phone: (530) 378-0486
Hours: Monday – Friday, 8 a.m. to 5 p.m. (Closed from 12 p.m. to 1 p.m. for lunch)

Shasta Lake Family Health & Dental Center

Address: 4215 Front Street, Shasta Lake City, CA 96019
Phone: (530) 276-9168
Hours: Monday – Friday, 8 a.m. to 5 p.m. (Closed from 12 p.m. to 1 p.m. for lunch)

Notice of Privacy Practices

Your Information.

Your Rights.

Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

As a part of our responsibilities, all employees and patients of Shasta Community Health, Dental, and Maternity Centers will follow this notice.

Shasta Community Health Center
a california health+ center

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Ask for details to be fixed on your paper or electronic medical record
- Ask for confidential, or private, communication
- Ask us to limit the details we share
- Get a list of who we have shared your information with
- Get a copy of this privacy notice
- Choose someone to act for you (such as a Healthcare Proxy, or someone with Power of Attorney)
- File a complaint if you believe we have failed to protect your privacy rights

*See page 2 and 3 for details on these rights and how you can use them.

Your Choices

You have some choices in the way that we use and share information if we:

- Talk to your family and friends about your health
- Give disaster relief
- Place you in our clinic directory, unless you let us know that you object
- Give mental health care
- Market our services and sell your information

*See page 4 for details on these choices and how to choose them.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our health care center
- Bill for services we give you
- Help with public health and safety issues
- Do research
- Follow with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

*See page 5 and 6 for details on these uses and disclosures.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our duties to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. SCHC requires this request to be in written form.
  Authorization to Release Information Form
- We will give you a copy or a summary of your health information, usually within 15 days of your request. We may charge a fair fee for labor plus $0.25 per page. This fee cannot exceed $6.50, with postage, labor, and supplies. (Health and Safety Code Section 123110)
- You can ask SCHC to send your electronic e-health record to a third party. SCHC may only charge for labor costs.
- We can deny access to all or part of your medical record. We must give a written reason within 5 working days.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is wrong or incomplete. Ask us how to do this.
  Medical Record Amendment Form
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can let us know how you would like to be contacted, for example: by home or office phone, or to send mail to a different address.
  Request for Confidential Communications Form
- We will say "yes" to all fair requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  Request for Restriction of Health Record Form
- If you pay out of your own pocket for a health care service or item, you can ask us not to bill your health insurance plan.
- We will say "yes" unless a law requires us to share that information.

continued on the next page

Get a list of who we have shared your information with

- You can ask for a list of times we have shared your health information for up to six years before the date you ask. We will tell you who we shared it with, and why. We will also tell you if we were legally required to without your express consent. Examples of why we would do this are for the California Department of Public Health, or other licensing body, and for the purpose of reviewing patient files to review quality of care and compliance with the law.

  Request for Accounting of Protected Health Information Disclosures Form

- We will give you a list of all of the times we have shared your information, except for those about treatment, payment, and health care operations, and certain other times (such as any you asked us to make). The first request in a year is free, but we may charge a fair fee based on our cost if you make another request within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to get the notice electronically. We will give you a paper copy as soon as possible.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, or healthcare proxy, that person can exercise your rights and make choices about your health information.
- We will make sure that person has this authority and can act for you before we take any action.

File a complaint if you feel we have failed to protect your rights

- You can complain if you feel we have failed to protect your rights. You must make your complaint in writing within 180 days (6 months) of when you suspect it happened. Give as much detail as you can.

  To submit a grievance:

  1. Go to www.shastahealth.org.
  2. Navigate to the upper right-hand corner of the homepage and click on "Submit a Grievance."
  3. On the next page, fill in all parts of the Patient Grievance Resolution form.
  4. After submitting your grievance, be sure to copy down the 12-digit "Report Key" provided to you. This key will allow you to follow up on your grievance, to send additional information, and to attach documents if you need to.
  5. You will be notified after your grievance has been received and we will respond to your grievance within 30 days.

- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights one of three ways:

  1. Mail: 200 Independence Ave., S.W., Washington, D.C. 20201
  2. Phone: 1-877-696-6775
  3. Online: http://www.hhs.gov/ocr/privacy/hipaa/complaints/

- We will not take action against you for filing a complaint.

Your Choices

For certain health information, you can tell us what you want to share.
You can tell us how you want us to share your information in the situations listed below. Let us know what you want us to do and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Take away this consent at any time. This can be done by telling us verbally or in writing.
- Share information in a disaster relief situation
- **Health Information Exchange** - We can share your data with a Health Information Organization (HIO). Your data will be made available by the HIO to others involved in your health care, unless you choose not to allow them access. You can do this by filling out the Opt-out form found on the SACVALLEY MEDSHARE website: http://sacvalleyms.org/.
- **Appointment Reminders** - If we call you to remind you of an appointment at one of our health centers, we will only leave the name of the center and the time of appointment. Please let us know if you do NOT wish to be called or contacted by mail.

  Request for Confidential Communications Form

  You may ask to be contacted in other ways like text message or email.

  Communication Preferences Form

If you are not able to tell us what you would like, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to help with a serious and impending threat to health or safety.

We never share your information unless you give us written consent when you are seen for these reasons only:

- Most psychotherapy notes
- HIV status
- Substance use

Our Uses and Disclosures

How do we typically use or share your health information?

Most of the time we use or share your health information in these ways:

Treat you (Treatment)	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health.*
Bill for your services (Payment)	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*
Run our health centers (Operations)	• We can use and share your health information to run our health centers, improve your care, and contact you when needed.	*Example: We use health information about you to manage your treatment and services.*

What other ways we can use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that help to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these reasons. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain reasons such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting bad or severe reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Business associates

- A business associate is a person or group of people that do jobs or tasks that involve the use or sharing of protected health information (PHI) for a covered entity. SCHC is a covered entity. These business associates are held to the following standards:
  - All HIPAA (Health Information Portability and Accountability Act) security administrative safeguards
  - Physical and technical safeguards
  - Security policies, procedures, and documentation requirements

continued on the next page

Do research	• We can use or share your information for health research.
Follow the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if they want to see that we are following federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ collection organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director if you pass away.

Address worker's compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • For correctional facility purposes
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to an order to attend court (a subpoena).

Our Responsibilities

- We are required by law to keep the privacy and security of your protected health information (PHI).
- It is our duty to protect the privacy of all our patients. We must also protect our employee's privacy. It is against SCHC policy and California law to purposely record or take pictures of confidential information by way of an electronic device or recording device (including cell phones) unless express consent is given by your clinician.
- We will let you know right away if a breach occurs that may have compromised the privacy or security of your information.

continued on the next page

- SCHC is including HITECH (Health Information Technology for Economic and Clinical Health) Act provisions to its Notice as follows:

  Under HITECH, SCHC is required to notify you if your PHI has been breached. This notice has to be made by certified mail within 15 days of the event. A breach occurs when an unauthorized use or disclosure that compromises the privacy or security of PHI poses a significant risk for financial, reputational, or other harm to the individual. In other words, a breach is when someone gains access to or shares your PHI without your consent. This could put you at greater risk for fraud, harm your identity, or could impact you in other harmful ways. This notice must:

  1. Give details of what happened, including the date of the breach and the date of the discovery
  2. Have the steps that you should take to protect yourself from any harm that might result from the breach
  3. Give details of what SCHC is doing to investigate the breach, reduce losses, and to protect against further breaches

- We must follow the duties and privacy practices listed in this notice and give you a copy of it.
- We will not use or share your information other than as listed here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site www.shastahealth.org.

Other Instructions for this Notice

This notice is effective January 1, 2019. Previous versions were effective April 1, 2003 and amended February 17, 2010, and January 1, 2017.

For questions regarding this notice, contact:

Privacy Officer
1035 Placer Street
Redding, CA 96001
Phone: (530) 246-5986
privacy@shastahealth.org

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

Notice of Privacy Practices: Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Shasta Community Health Center (SCHC). Our "Notice of Privacy Practices" tells you how we may use and share your protected health information. We encourage you to review it carefully.

We may change our "Notice of Privacy Practices." If we change our notice, you may get a copy of the revised notice at any of our locations, by calling (530) 246-5710, or online at www.shastahealth.org.

If you have any questions about our "Notice of Privacy Practices," please contact our Privacy Officer by phone at (530) 246-5986 or by email at privacy@shastahealth.org.

I acknowledge receipt of the "Notice of Privacy Practices" of SCHC.

Patient Name:	Date:
Sign Here:	
Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative ☐ Foster Parent	
If signing for the patient, print your name:	

Shasta Community Health Center
a californiahealth+ center

Patient Rights and Responsibilities

Shasta Community Health Center's (SCHC) purpose is to provide high quality health care to our community with compassion and understanding. Our driving force is to remove barriers to healthcare and promote wellness for our entire community.

We want to be a partner in your health to give you the best possible care. This happens when you are well informed about your options, take part in your treatment decisions, and can speak openly with your clinician and your health care team. We respect the personal choices and values of all our patients. It is our goal to make sure your rights as a patient are respected and to act as a partner in your decision-making process.

While you are our patient, **you have the following rights**:

- ✓ **Access to Care**
  - To access care without worry that you will be treated poorly because of your gender, sexual orientation, culture, economics, education, religion, language, age, race, color, ancestry, creed, national origin, presence of a disability, or the source of payment for your care.
  - To get a timely response for any reasonable request made for services within the Health Center's ability, stated mission, applicable laws, and regulations. The Health Center will give each patient the health services they need to the best of its ability.
  - To access urgent or emergency services when needed.
- ✓ **Thoughtful and Respectful Care**
  - To service that focuses on your comfort and dignity.
  - To service that reflects your desires, or that of your legal representative, while taking into account your physical limits as well as your social, mental, spiritual, and cultural concerns.
  - To the best and most complete care we can offer.
- ✓ **Knowledge and Information**
  - To know the name of the clinician who is in charge of your care and the names of other health care professionals who will see you.
  - To know ahead of time about future appointments, including the time, place, and who will be giving you the care.
  - To get information from the clinician about your care and treatment in a way that you can understand.
  - To informed consent, which is to get all the details you may need about any proposed treatment or procedure. This will allow you to agree or to refuse the treatment plan.
- ✓ **Active Involvement in Your Care**
  - To work with your clinician in making decisions about your care. If you choose to select a representative, they also have this right.
  - To get information about and to create advance directives, which is a plan for your care if you can't speak for yourself.

- ✓ **Privacy and Confidentiality**
  - To privacy about your care. This includes anything talked about during your visit, the exam, and treatment.
  - To confidential handling of all information, communications, and records about your care and treatment. Written permission from you or your legal representative must be given before medical records can be shared with anyone not directly involved with your care. You or your legal representative can get the details contained in your medical record, within the limits of the law.

- ✓ **Respect for Patient Rights**
  - To express concern or complaints about your care and have them addressed without fear of risking the quality of your care or future access to care, and to expect a reasonable and timely response to your concerns.
  - To expect that all SCHC staff members will respect your patient rights as well as any person that is legally responsible for your medical decisions.

While you are our patient, **you have the following responsibilities**:

- ✓ **Patient Responsibilities**
  - To give your health care team correct and complete information.
  - To let your clinician know if you do or do not understand the treatment you are offered and what you are expected to do.
  - To accept responsibility for your health outcomes by following the treatment plan given by your clinician or letting your clinician know if you choose not to follow that plan.
  - To be kind and respectful to others, both patients and staff.
  - To not bring any type of weapon to any of the health center locations.
  - To keep appointments as scheduled, or to notify SCHC if cancelling at least two hours before that appointment time and date.

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

Patient Registration

Personal Information: Give us some details about the patient so we can get to know them better.

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security #: _____

Gender at Birth: ☐ Male ☐ Female

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address (if different): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Are you a veteran?
☐ Yes ☐ No

Are you homeless or at risk of being homeless? ☐ Yes ☐ No

Race? (Check all that apply):

☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese

☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro

☐ Samoan ☐ Black/African American ☐ American Indian/Alaskan Native ☐ White

☐ More than one race ☐ Don't know or don't want to say

Ethnicity?

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban

☐ Other Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Don't know or don't want to say

What language do you prefer?

☐ English ☐ ASL ☐ Spanish (Español) ☐ Mien (Mienh) ☐ Other: _____

Would you like to have an interpreter during your medical visits? ☐ Yes ☐ No

MRN: _____

Employee ID #: _____
Office Use Only

Parent/Legal Guardian Information

Only needed if patient is under 18

Parent/Legal Guardian #1: _____ Birthdate: _____

Type of Parent: ☐ Biological ☐ Adoptive ☐ Foster ☐ Other: _____

Parent/Legal Guardian #2: _____ Birthdate: _____

Type of Parent: ☐ Biological ☐ Adoptive ☐ Foster ☐ Other: _____

Financial & Insurance Information: Here we need the details about the account holder. This is the person that will be paying for services.

Patient Insurance: ☐ Medicare ☐ Medi-Cal ☐ Private Insurance

☐ Other: _____

Account Holder or Person Paying

Insurance is asked to pay first. Sometimes there is still money owed.
Who should we send statements to? (Statements may include limited personal health information.)

☐ Patient ☐ Other

If you marked other, please fill out the details below:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Sign Here: By signing here you are agreeing that the details given on this form are true and correct.

Patient or Account Holder: _____ Date: _____

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

My Consent for Care

Thank you for seeking care from Shasta Community Health Center (SCHC). SCHC is a Federally Qualified Health Center and Integrated Teaching Health Center. Our sites include Shasta Community Health Center and Shasta Community Maternity Center in Redding, Anderson Family Health Center, Shasta Lake Family Health Center, and all SCHC Dental Centers. For a complete listing of all SCHC locations and clinicians, please go to www.shastahealth.org.

This Consent for Care Agreement authorizes SCHC to provide you with medical, specialty, or dental care. This form must be signed before you can be treated. The only exception is in cases of emergency.

By signing this form:

1. I consent to diagnosis, care and treatment that is considered necessary or recommended by my clinician(s) and other healthcare clinicians.
2. I understand that my consent will be carried over to other SCHC locations, if I choose another clinician or service within SCHC.
3. I understand that SCHC is a Teaching Health Center. I understand this means that physician and dental residents, nurse practitioner fellows, physician assistant fellows, and other licensed healthcare professionals "in training" may be involved in my care and treatment.

I have read, understand and agree to this Consent for Care agreement.

Patient Name:	Date:
Sign Here:	
Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative ☐ Foster Parent	
If signing for the patient, print your name:	

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

Communication Preferences

Tell us how you would like us to communicate with you. We will be in contact about appointment reminders, preventative healthcare you may be due for, and messages from your healthcare team.

NOTE: Regular text messaging is not secure. This means there may be some risk that information could be read by someone else besides you. For that reason, we are required by law to obtain your consent if you want to receive text messages from SCHC.

Phone Preferences

☐ I want to receive phone calls from SCHC at my:

Home phone number: (_____)_____

☐ I want to receive voice messages at my home number, and I understand that no protected health information (PHI) will be left in the message.

Cell phone number: (_____)_____

☐ I want to receive voice messages at my cell number, and I understand that no PHI will be left in the message.

☐ I DO NOT want to be contacted by phone

Text Messaging Preferences

☐ I want to receive text messages at this number: (_____)_____
I know it is my responsibility to let SCHC know right away if my number changes. I also know that such messages cannot be sent securely and I risk information being disclosed.

☐ I DO NOT want to receive text messages

Patient Portal

We use a patient portal called Shasta Health Connect (SHC). With SHC you can send and receive secure email, request appointments, request medication refills, and review your recent labs results and medical records. **This is the best option for being able to securely and safely receive and discuss PHI with your health care team.**

In order to sign up, you must provide an email address. Would you like to sign up today?

☐ Yes, my email address is: _____

☐ No, I do not want to sign up at this time

Patient Name:	Date:
Sign Here:	
Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative	
If signing for the patient, print your name:	

Shasta Community Health Center
a californiahealth+ center

New Patient Questions

Name: _____

Date of Birth: _____

1.	Do you have any cardiac (heart) issues?	☐ Yes	☐ No
2.	Do you have high blood pressure?	☐ Yes	☐ No
3.	Do you have diabetes?	☐ Yes	☐ No
4.	Have you had a recent stroke?	☐ Yes	☐ No
5.	Do you have any lung or breathing problems?	☐ Yes	☐ No
6.	Have you or anyone in your family ever had cancer?	☐ Yes	☐ No
7.	Have you had any seizures?	☐ Yes	☐ No
8.	Have you had any diseases of the liver?	☐ Yes	☐ No
9.	Have you had surgery, been hospitalized, or gone to the emergency room within the last two months?	☐ Yes	☐ No
10.	How many prescription medications do you take? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11 or more		

11. What are your prescription medications and when are you going to run out of them?

Example: Atenolol 1 week

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

If you run out of space, finish your list on the back of the page.

12.	Do you have a condition that causes you daily pain?	☐ Yes	☐ No
13.	If yes, are you taking prescription pain medications?	☐ Yes	☐ No

14. How soon do you feel that you need to be seen and why?

_____

_____

15.	Have you had a specialty care such as cardiology, neurology, psychiatry, etc.?	☐ Yes	☐ No

16. If yes, what kind of care?

_____

_____

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

Adult Patient History Form

Patient name: _____ Today's date: _____

Nickname: _____ Date of birth: _____

Allergies: Are you allergic to any medicine or food? ☐ No ☐ Yes
If yes, please list your medicine and food allergies.

Medicine or Food	What happens when you take or eat it?
Example: amoxicillin	*I break out in hives.*
Example: peanuts	*I can't breathe.*
1.	
2.	
3.	

Past Medical History: Do you have or have you been **diagnosed and/or treated** for any of the following?

☐ Anemia / blood disorder → Type: _____	☐ Kidney / urinary tract problems → Type: _____
☐ Arthritis → Type: _____	☐ Liver problems or hepatitis → Type: _____
☐ Blood clots	☐ Lung or respiratory problems → Type: _____
☐ Bone / joint disease or injury → Type: _____	☐ Mental health problems / depression / anxiety → Type: _____
☐ Cancer → Type: _____	☐ Skin problems / eczema → Type: _____
☐ Diabetes → Type: _____	☐ Stomach or bowel problems / constipation → Type: _____
☐ Epilepsy / seizure disorder	☐ Stroke
☐ Eye or ear problems → Type: _____	☐ Thyroid disease
☐ Heart problems → Type: _____	☐ Tuberculosis
☐ High blood pressure	☐ Women's health problems → Type: _____
☐ High cholesterol	☐ Other: _____
☐ HIV/AIDS	☐ Other: _____

MRN: _____

Employee ID #: _____
Office Use Only

Surgical History: Please list any surgeries you have had and the year they took place.

☐ Gallbladder →Year: _____	☐ Appendix →Year: _____	☐ Tonsils →Year: _____
Other:		Year:
Other:		Year:
Other:		Year:
Other:		Year:

Family History: Have your close family members had any of the following?

Family Member	Medical Condition
Mother ☐ Alive ☐ Passed Age: _____	☐ Heart problems ☐ Stroke ☐ High blood pressure ☐ High cholesterol ☐ Mental illness ☐ Alcohol/drug abuse ☐ Cancer, type: _____ ☐ Diabetes, type: _____ ☐ Genetic disorder (runs in family) ☐ Other: _____
Father ☐ Alive ☐ Passed Age: _____	☐ Heart problems ☐ Stroke ☐ High blood pressure ☐ High cholesterol ☐ Mental illness ☐ Alcohol/drug abuse ☐ Cancer, type: _____ ☐ Diabetes, type: _____ ☐ Genetic disorder (runs in family) ☐ Other: _____
Sister(s) # Alive: _____ # Passed: _____ Age(s): _____	☐ Heart problems ☐ Stroke ☐ High blood pressure ☐ High cholesterol ☐ Mental illness ☐ Alcohol/drug abuse ☐ Cancer, type: _____ ☐ Diabetes, type: _____ ☐ Genetic disorder (runs in family) ☐ Other: _____
Brother(s) # Alive: _____ # Passed: _____ Age(s): _____	☐ Heart problems ☐ Stroke ☐ High blood pressure ☐ High cholesterol ☐ Mental illness ☐ Alcohol/drug abuse ☐ Cancer, type: _____ ☐ Diabetes, type: _____ ☐ Genetic disorder (runs in family) ☐ Other: _____
Grandmother(s) ☐ Alive ☐ Passed Age(s): _____	☐ Heart problems ☐ Stroke ☐ High blood pressure ☐ High cholesterol ☐ Mental illness ☐ Alcohol/drug abuse ☐ Cancer, type: _____ ☐ Diabetes, type: _____ ☐ Genetic disorder (runs in family) ☐ Other: _____
Grandfather(s) ☐ Alive ☐ Passed Age(s): _____	☐ Heart problems ☐ Stroke ☐ High blood pressure ☐ High cholesterol ☐ Mental illness ☐ Alcohol/drug abuse ☐ Cancer, type: _____ ☐ Diabetes, type: _____ ☐ Genetic disorder (runs in family) ☐ Other: _____

MRN: _____

Employee ID #: _____
Office Use Only

Social History:

Current Employment Status	Alcohol Use
☐ Work, full-time ☐ Work, part-time ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Other: _____ → Current job? _____ → Past job? _____	Do you drink alcohol? ☐ No ☐ Yes ☐ Former - Year Quit: _____ → Type: ☐ Beer ☐ Hard liquor ☐ Wine ☐ Other: _____ → How often? _____ → How much? _____ → Last Drink? _____

Tobacco & Drug Use

Have you ever actively used tobacco products? ☐ No ☐ Yes

→ Former smoker or chewer? ☐ No ☐ Yes Age started? _____ Age stopped? _____

→ Are you currently using? ☐ No ☐ Yes Average Daily Use: _____

Have you ever used marijuana? ☐ No ☐ Yes

→ If yes, are you currently using? ☐ No ☐ Yes

Have you ever used drugs such as meth, cocaine or IV drugs? ☐ No ☐ Yes

→ If yes, are you currently using? ☐ No ☐ Yes

Past Immunizations (Shots): Have you had any of the following shots?

☐ Flu	Date:	Have the record? ☐ No ☐ Yes
☐ Hepatitis A	Date:	Have the record? ☐ No ☐ Yes
☐ Hepatitis B	Date:	Have the record? ☐ No ☐ Yes
☐ Pneumonia	Date:	Have the record? ☐ No ☐ Yes
☐ Tetanus	Date:	Have the record? ☐ No ☐ Yes
☐ Tuberculosis Skin Test	Date:	Have the record? ☐ No ☐ Yes
☐ Shingles	Date:	Have the record? ☐ No ☐ Yes
☐ Whooping Cough	Date:	Have the record? ☐ No ☐ Yes

Reproductive Health History:

Have you ever had a sexually transmitted disease (STD)? → If yes, what kind? _____	☐ No	☐ Yes
Are you taking hormone replacement therapy?	☐ No	☐ Yes
Are you having periods? → If yes, date of last menstrual period: _____ → If No, when did they stop? _____ (age) or _____ (year)	☐ No	☐ Yes
How old were you when you started having periods?	Age: _____	
Are you currently pregnant?	☐ No ☐ Yes ☐ Maybe	
Have you ever been pregnant? → If yes, how many times? _____ → If yes, how many times carried to full term? _____ → If yes, how many times preterm birth? _____ → If yes, how many abortions? _____ → If yes, how many miscarriages? _____ → If yes, how many children do you have? _____	☐ No	☐ Yes
Have you had a mammogram? → If yes, when and where? _____	☐ No	☐ Yes
Have you had a pap smear? → If yes, when and where? _____	☐ No	☐ Yes
Have you had a hysterectomy? → If yes, what year? _____ → If yes, was it to remove cancer? ☐ No ☐ Yes → If yes, what type? ☐ Cervical ☐ Ovarian ☐ Uterine	☐ No	☐ Yes

Medications: Please bring all current medications (pills, inhalers, creams, patches) to your first visit. This includes over the counter medications, vitamins, and supplements.

If you did not bring them, please list them below. You can also provide your medication list.

Name of the Medicine	Dose (include strength & number of pills per day)
Example: aspirin	*81 mg tablet once daily*
1.	
2.	
3.	
4.	
5.	

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

How We Share Protected Health Information (PHI)

Shasta Community Health Center (SCHC) has safeguards in place to protect our patients' medical and private information. Our mission is to give quality health care and make sure your privacy needs are met.

Do I need to fill this form out?
Yes, we need to know your Emergency Contact. Listing anyone else is optional. SCHC will only share your PHI to assist us in your treatment, to share minimum necessary information for payment from your insurer or other sources, and in our operations designed to ensure the quality of care you receive. This includes sharing only necessary information with those you choose. Here is how we define those support roles:

1) **Emergency Contact**—This is someone we can share information with *only* in the event of an emergency. If you wish to share information more freely, please select Caregiver.
2) **Next of Kin**—This is a relative who we can share information with only in the event where you are incapacitated (unable to speak for yourself). If you wish to share information more freely, please select Caregiver.
3) **Caregiver**—This is *anyone* who you feel comfortable with sharing information with, such as a relative, close friend, or home care aide. You don't necessarily need to be dependent on them for daily living in order to designate them as someone who is part of your care. We may need to use our professional judgement to decide whether someone is a caregiver and if sharing your PHI with them would be best for your care.

What if I want to make sure my caregiver can get copies of my record?
You can fill out the *Authorization to Release Health Records* form to request your medical record in paper or electronic format to share with your caregiver or relative.

What if I do not want my PHI shared with a certain person or doctor's office?
You can ask to restrict the use or sharing of your PHI by filling out the *Request for Restriction of Health Record* form if you do not want your PHI shared with a certain person, such as your caregiver or other health care provider.

More questions? Please review SCHC's *Notice of Privacy Practices*.

First and Last Name:	
Phone Number:	Relationship to Patient:
Support Role: ☐ Caregiver ☐ Next of Kin ☐ Emergency Contact	
First and Last Name:	
Phone Number:	Relationship to Patient:
Support Role: ☐ Caregiver ☐ Next of Kin ☐ Emergency Contact	

Patient Information:

Patient Name:	Date:
Sign Here:	
Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative	
If signing for the patient, print your name:	

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

☐ URGENT

Authorization to Release Health Records

Patient Name: _____ **Date of Birth:** ____/____/_____

Other names used: _____ **Other identifier:** _____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email (optional): _____

I hereby authorize: (check one)

☐ **Shasta Community Health Center** (SCHC) 1035 Placer St., Redding, CA 96001, Phone: (530) 246-5710, Fax: (530) 245-0705

☐ **Other:** _____
Name of person / entity to RELEASE health records

_____
Street Address, City, State, Zip Code Phone # Fax #

To release health records to (Recipient*): (check one)

☐ **Shasta Community Health Center** (SCHC) 1035 Placer St., Redding, CA 96001, Phone: (530) 246-5710, Fax: (530) 245-0705

☐ **Patient or Legal Representative**

☐ **Other:** _____
Name of person / entity to RECEIVE health records

_____
Street Address, City, State, Zip Code Phone # Fax #

*Recipient(s) may include individuals, entities with a treating provider relationship to patient, third-party payers, or other entities without a treating provider relationship patient. If recipient entity does not have a treating provider relationship to patient and is not a third-party payer, please indicate the name of the recipient entity, and: (1) the name(s) of individual participant(s), or (2) the name(s) of an entity participant(s) that has a treating provider relationship with the patient; or (3) a general designation** of an individual or entity participant(s) or class of participants that must be limited to a participant(s) who has a treating provider relationship with the patient whose information is being disclosed.

**When using such a general designation and disclosing information covered by substance use disorder information covered by federal regulations at 42 CFR Part 2 ("Part 2"), patient (or other individual authorized to sign in lieu of the patient) understands that, upon their request and consistent with Part 2, they must be provided a list of entities to which their information has been disclosed pursuant to such general designation.

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

☐ URGENT

Patient Name: _____ **Date of Birth:** ____/____/_____

Please **DESCRIBE** the **PURPOSE** of the disclosure as specifically as possible:

_____

_____

Date range of information to release: _____ **to** _____

What information would you like shared?	
☐ Immunization (shot) records	☐ Colonoscopy / Pathology
☐ Current medication list	☐ Current problem list
☐ Office visit notes / CHDP / Well Child exam	☐ Hospital reports
☐ Lab results	☐ X-ray / Imaging / Diagnostic Reports
☐ Pap / Pathology / HPV	☐ Retinal / Diabetic Eye Exam
☐ Specialist consultation reports	☐ Other: _____

I approve the release of the following protected or sensitive information: (initial REQUIRED)

_____ Mental Health _____ Psychotherapy notes _____ HIV test results

_____ Substance Use Disorder records (covered by 42 CFR Part 2 ("Part 2") ("Confidentiality of Substance Use Disorder Patient Records")) **Please answer the following:**

Please **DESCRIBE HOW MUCH** and **WHAT KIND** of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed:

_____

_____

_____

➔ **Notice:** Fees may apply for copies of your records. _____ **(initial)**

➔ I understand the organization I am requesting FROM may only accept this release via email, which is not a guaranteed form of secure communication. _____ **(initial)** (Kaiser / Other)

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

☐ URGENT

Patient Name: _____ **Date of Birth:** ____/____/_____

Your Rights: This authorization to release health information is given freely. I understand that I may refuse to sign this authorization and further understand that I need not sign this form in order to be treated at SCHC. I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that any such revocation is in writing and provided to SCHC's Health Information Services (HIS) Department. SCHC may not condition my treatment on my signing this form. A photocopy or fax of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I know I can look at or get copies of the information that's being shared. This right is given by 45 CFR 164.524. I know if I give approval the information shared with SCHC may be shared again with another medical center. This may not be protected by federal confidentiality rules.

I am signing this authorization voluntarily and that my treatment will not be affected if I do not sign this authorization. (45 CFR 164.508 c2ii)

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Unless required by law, California law prohibits the Recipient from further disclosing your health information unless the recipient obtains another authorization from you. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I know if I have questions about sharing my health information, I can call SCHC Medical Records at (530) 246-5758.

Expiration of Authorization: Unless otherwise revoked, this authorization expires ___/___/_____. If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

Signature: _____ **Date:**_____

If Legal Representative (List relationship to the patient or why you have authority to sign):

Printed name: _____ **Relationship:** _____

Witness (if needed): _____

Office Use Only: (initial/date) *ROI Faxed/Sent:* _____ *PHI log:* _____

Released by: _____ *Preferred Delivery: (circle) Paper / CD / Mail / Pick Up / Fax / Electronic*

Shasta Community Health Center
a californiahealth+ center

Sliding Fee Discount Program
For Medical and Dental Services

Please read this before completing the Sliding Fee Discount Program Application.

Shasta Community Health Center's mission is to provide quality health and dental care services to everyone. We are a private, nonprofit, federally funded health care program with locations in Redding, Anderson, and Shasta Lake. We bill most insurances and we accept patients without regard to their financial status. We offer a wide range of services to patients through the sliding-fee discount program. This program helps ensure that cost is not a barrier to anyone in our community seeking health care services.

To determine your eligibility for this federally funded program, documentation of your income (or lack of income) and household size is required. You must update this information at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept completely confidential. If you have a high insurance deductible, you may be eligible for the Sliding Fee Discount Program.

If you qualify for the sliding fee program, you will be required to pay a minimum fee of $15.00 - $55.00. Your payment is due at the time of service.

You must complete the financial information form every year to determine your eligibility and discount. This information includes:

- ✓ Your total household income from all sources before taxes.
- ✓ Number of household members living in your household.
- ✓ You may be asked to provide proof of your total household income. This can be in the form of check stubs, bank statement, tax returns, or any other document that proves your household income.

Your discount may change if your income or family size changes.

Sliding Fee Discount payments may be refundable whenever SCHC receives payment from your insurance for that date of service.

Services offered under the SCHC Sliding Fee Discount Program are limited to those deemed medically necessary by appropriate Center staff. Cosmetic, elective, or job-mandated health services do not qualify for the Sliding Fee Discount Program.

Labs, Radiology, and Special Procedures:

If you qualify for our Sliding Fee Discount Program, your labs are covered if you have them done by Quest Diagnostics. If you do not qualify and you are self-pay, you must pay a discounted "council fee" at the time of checkout with a visit coordinator.

There are separate charges for performing and reading an x-ray. MD Imaging (MDI) offers a discount program, but it is a separate program. Please make discount arrangements directly with MDI.

Your health care provider may order special diagnostic studies (such as a sonogram or CT) not performed at SCHC. You will be responsible for 100% of those charges and must arrange to pay the facilities that provide them.

Please let us know if you have any questions about our programs or services. We are here to help! You can contact our Billing Department at (530) 246-5934.

Shasta Community Health Center
a californiahealth+ center

HOH MRN: _____

Employee ID #: _____
Office Use Only

Sliding Fee Application

Personal Information: Give us some details about you and your household.

Patient Information

Last Name: _____ First Name: _____

Middle Initial: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Head of Household

This is usually the person who makes the most money in the home.

Same as patient? ☐ Yes ☐ No - If no, please let us know who is Head of Household:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: _____ Date of Birth: _____

Other People in the Household *(People who share all money made and bills - children too)*	**Relationship to Head of Household**	**Date of Birth**
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
TOTAL MEMBERS OF HOUSEHOLD		

HOH MRN: _____

Employee ID #: _____
Office Use Only

Financial & Household Information: Tell us how much money you and the people in your household make.

Section A: How much money is made from all jobs, including self-employment?

- ☐ Monthly $ _____
- ☐ Weekly $ _____
- ☐ Every 2 Weeks $ _____
- ☐ Twice a Month $ _____

TOTAL (A)	$

Section B: Other Sources of Money	Monthly Total
Child Support/Alimony	$
Unemployment	$
Disability/Workers Comp	$
Interest/Dividends	$
Social Security/SSI/Survivors Benefits	$
Pensions	$
Rental Income	$
Public Assistance *(not food stamps)*	$
Education Assistance	$
TOTAL (B)	**$**

Sign Here: By signing below you are saying that you agree to the statement in the box.

I know that giving false information may disqualify me for discounts. I also know, if disqualified, I will have to pay for the full fee and will not be eligible for the Sliding Fee Program.

I know that just because I apply for a discount does not mean I will get a discount. I also know that if I do not tell SCHC about any changes to how much money I make or the amount of people in the house, SCHC may immediately take away any discounts.

I know that information on this form will only be shared internally for purposes of the Sliding Fee Program.

Person Responsible for Paying

Sign: _____ **Date of Birth:** _____

Name & Relationship: _____ **Date:** _____

This form does not bind other agencies to honor the given discount and they may ask for more information.

--- OFFICE USE ONLY ---

Take the number reported in (A) and times it by the appropriate amount to get (A*)
Weekly: x 4.33 Every 2 Weeks: x 2.167 Twice a Month: x 2

Household size: _____	Monthly Income: Wages (A*): $ _____ Other (B): $ _____ **TOTAL: $ _____ (A* + B)**	Category: _____ (A, B, C, D or Self) Fee: $ _____	Total Annual Income: $ _____

Reviewed By: _____ O&E Referral: _____ Expiration Date: _____

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

Financial Policy
For Medical and Dental Services & Fees

We feel that a part of good health care is having a clear financial policy that is shared with our patients. Please take time to review this policy. We want to make sure you understand it. Financial details can be confusing. Let us know if you need us to explain anything.

Payment: Here are some details that you should know about our payment policy.

Any fees that you need to pay are due at the time of your visit. This policy is for patients with or without health insurance.

We will take cash, check, or credit card.

If you have insurance, your payment includes any un-paid:

- ✓ Deductibles
- ✓ Co-insurance
- ✓ Co-payment amount
- ✓ Non-covered fees from your insurance company

We ask for a copy of an ID card or license to help protect you from identity theft.

Self-Pay or Prompt Pay Patients (pay at your visit) Who have insurance:

Did you know that if you pay for your medical fees at the time of your visit, you may qualify for a 50% discount?

- ✓ You don't need insurance to qualify
- ✓ This does not include dental fees

Insurance: Here are some details that you should know about insurance.

We are a participating provider or considered in-network with a few plans; find out if we are with your plan by contacting your insurance company.

Learn what services and clinicians are covered before your visit by calling your insurance benefits department.

If our clinicians or services are not listed in your plan's network (on their list of clinicians or services they have a contract with):

- ✓ You may have to pay for part of, or the entire bill.
- ✓ We will send the claim to your insurance for you.
- ✓ Your insurance might send the payment for you to bring and pay at your SCHC visit.

You must bring your insurance card to every visit. We will need to copy both sides.

If you have insurance, we will send them the bill.

If you do not have insurance we will send the bill to you.

If the insurance does not cover the fees the patient will need to pay. If we get a payment from your insurance after you pay, we will refund what is due to you.

MRN: _____

Employee ID #: _____
Office Use Only

If you are a member of a HMO or managed care plan:
You must see your primary care provider (the clinician you see for your general health care).
If your insurance does not cover part of your fee:
You might qualify for our sliding fee discount program for the things that are not covered. Medical and Dental have different rules.

Other Notes: Here are some other things to think about.

Diagnostic tests are billed separately.
If you are referred to another provider or other services, any bills or fees you get from them will be between you and them. They may bill differently than we do at SCHC.

If you have questions about your bill or fees

Our Billing Team is happy to help! You can call us at (**530) 246-5934**.

Sign: By signing below you are saying that you have read and understand the details of the SCHC Financial Policy.

Patient Name:	Date:
Sign Here:	
Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative	
If signing for the patient, print your name:	

Shasta Community Health Center
a californiahealth+ center

Save on Your Prescription Drugs

While Supporting Your Community

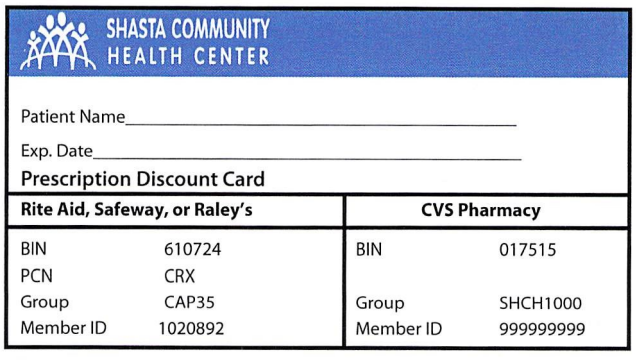
Did you know Shasta Community Health Center (SCHC) is part of the 340B Drug Discount Program?

What This Means:

- Lower cost drugs if you don't have insurance
- Better communication between your pharmacy and your clinician
- Supporting your local community health center

SCHC is a Federally-Qualified Health Center which allows us to share this program with our patients. Show your 340B card at a pharmacy in the SCHC Pharmacy Network and you could save money while supporting your community health center. Patients who don't have insurance may get drugs at a lower cost. Patients with insurance get benefits through expanded services at SCHC.

Ask us for your 340B Card today!

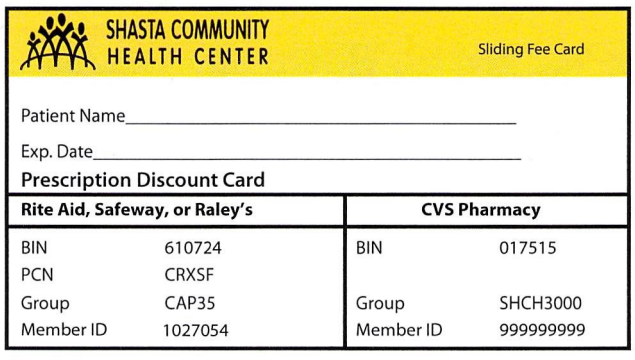

SHASTA COMMUNITY HEALTH CENTER

Patient Name_____

Exp. Date_____

Prescription Discount Card

Rite Aid, Safeway, or Raley's		CVS Pharmacy	
BIN	610724	BIN	017515
PCN	CRX		
Group	CAP35	Group	SHCH1000
Member ID	1020892	Member ID	999999999


SHASTA COMMUNITY HEALTH CENTER

Sliding Fee Card

Patient Name_____

Exp. Date_____

Prescription Discount Card

Rite Aid, Safeway, or Raley's		CVS Pharmacy	
BIN	610724	BIN	017515
PCN	CRXSF		
Group	CAP35	Group	SHCH3000
Member ID	1027054	Member ID	999999999

Note: The blue and white card is available to all patients. The yellow and white card is for uninsured patients who are eligible for our sliding fee.

Look on the back for a list of pharmacies that accept this program.

SCHC 340B Pharmacy Network:

CVS Pharmacy	
1060 E. Cypress Avenue, Redding	(530) 221-5575
3375 Placer Street, Redding	(530) 241-7328
1035 Placer Street, Suite 110, Redding	(530) 999-6073
2025 Court Street, Suite A, Redding	(530) 999-6072
317 Lake Boulevard, Suite B, Redding	(530) 999-6099
1280 Dana Drive, Redding (Inside Target)	(530) 224-1437
2975 East Street, Anderson	(530) 744-6024
455 South Main Street, Red Bluff	(530) 529-5530
1311 South Main Street, Weaverville	(530) 623-5555
Raley's	
201 Lake Boulevard, Redding	(530) 246-3511
Rite Aid Pharmacy	
3095 McMurray Drive, Anderson	(530) 365-5753
975 East Cypress Avenue, Redding	(530) 223-3995
6424 Westside Road, Redding	(530) 243-3616
1801 Eureka Way, Redding	(530) 243-5500
5350 Shasta Dam Boulevard, Shasta Lake	(530) 275-1532
Safeway Pharmacy	
2275 Pine Street, Redding	(530) 247-3040
1070 East Cypress Avenue, Redding	(530) 222-8274
2601 Balls Ferry Road, Anderson	(530) 365-1010
Walgreens Pharmacy	
980 East Cypress Avenue, Redding	(530) 221-5028
1775 Eureka Way, Redding	(530) 241-3294
115 Lake Boulevard, Redding	(530) 229-1519

Shasta Community Health Center
a californiahealth+ center

Your Right to Make Decisions About Medical Treatment

Understanding Advance Health Care Directives

This handout explains your right to make health care decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future.

A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.

- **Who makes decisions about my medical treatment?**
  Your doctors will give you information and advice about treatment. You have the right to choose what treatment is best for you. You can say "yes" to treatments you want. You can say "no" to any treatment that you don't want – even if the treatment might keep you alive longer.

- **How do I know what I want?**
  Your doctor will tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects." Your doctor must offer you information about problems that a specific medical treatment is likely to cause you.

  Often, more than one treatment might help you and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. The choice is yours to make and depends on what is important to you.

- **Can other people help with my decisions?**
  Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

- **Can I choose a relative or friend to make health care decisions for me?**
  Yes. You may tell your doctor that you want someone else to make health care decisions for you. Ask the doctor to list that person as your health care "surrogate" in your medical record. The surrogate's control over your medical decisions is effective only during treatment for your current illness or injury or, if you are in a medical facility, until you leave the facility.

- **What if I become too sick to make my own health care decisions?**
  If you haven't named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works, but sometimes everyone doesn't agree about what to do. That's why it is helpful if you can say in advance what you want to happen if you can't speak for yourself.

- **Do I have to wait until I am sick to express my wishes about health care?**
  No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other health care facility. You can use an Advance Health Care Directive to say who you want to speak for you and what kind of treatments you want. These documents are called "advance" because you prepare one before health care decisions need to be made. They are called "directives" because they state who will speak on your behalf and what should be done.

In California, the part of an advance directive you can use to appoint an agent to make health care decisions is called a Power of Attorney for Health Care. The part where you can express what you want done is called an Individual Health Care Instruction.

- **Who can make an advance directive?**
  You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

- **Who can I name as my health care agent?**
  You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made.

- **When does my health care agent begin making my medical decisions?**
  Usually, a health care agent will make decisions only after you lose the ability to make them yourself. But, if you wish, you can state in the Power of Attorney for Health Care that you want your health care agent to begin making decisions immediately.

- **How does my health care agent know what I would want?**
  After you choose your health care agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your health care agent knows what you want. You can also write your wishes down in our advance directive.

- **What if I don't want to name a health care agent?**
  You can still write out your wishes in your advance directive, without naming a health care agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment.

  Even if you have not filled out written Individual Health Care Instructions, you can discuss your wishes with your doctor, and ask your doctor to list those wishes in your medical record. Or you can discuss your wishes with your family members or friends. However, it will most likely be easier to follow your wishes if you write them down. If you do not plan ahead and you cannot communicate your wishes, the court will be asked to make your medical decisions.

- **What if I change my mind?**
  You can change or cancel your advance directive at any time as long as you can communicate your wishes. To change the person you want to make your health care decisions, you must sign a statement or tell the doctor in charge of your care.

- **What happens when someone else makes decisions about my treatment?**
  The same rules apply to anyone who makes health care decisions on your behalf – a health care agent, a surrogate whose name you gave to your doctor, or a person appointed by a court to make decisions for you. All are required to follow your Health Care Instructions or, if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate, health care agent, or court must try to determine what is in your best interest.

  The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the clinician must make a reasonable effort to find another health care provider to take over your treatment.

- **Will I still be treated if I don't make an advance directive?**
  Absolutely. You will still get medical treatment. We just want you to know that if you become

too sick to make decisions, someone else will have to make them for you. Remember that:

- ✓ A Power of Attorney for Health Care lets you name an agent to make decisions for you. Your agent can make most medical decisions – not just those about life sustaining treatment – when you can't speak for yourself. You can also let your agent make decisions earlier, if you wish.
- ✓ You can create Individual Healthcare Instructions by writing down your wishes about health care or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an Individual Healthcare Instruction provides a good way to make your wishes clear to your doctor and to anyone else who may be involved in deciding about treatment on your behalf.
- ✓ These two types of Advance Healthcare Directives may be used together or separately.

- **How can I get more information about making an advance directive?**
  Ask your doctor, nurse, social worker, or health care provider to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

  Reference Public Law 101-508.

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an immunization registry to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to limit who is able to access your records in the California Immunization Registry (CAIR).

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children need
- Make sure children meet requirements for shots and TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests or medical exemptions

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number. Health officials can also look at the registry to protect public health.

Patient and Parent Rights

It's your legal right to ask your provider:

- to prevent other providers and schools from accessing your (or your child's) registry records
- not to send shot appointment reminders
- for a copy of your or your child's shot/TB test records
- who has seen the records and to change any mistakes

No action is needed to be part of CAIR. Other CAIR providers, schools, and health officials automatically have access to your or your child's records.

If you want to limit who sees your or your child's records:

1. Check with your provider to see if they can lock your records in CAIR
2. If your provider can't, complete a Request to Lock My CAIR Record form at **CAIRweb.org/cair-forms.**
3. If you change your mind, complete the Request to Unlock My CAIR Record form.
4. Fax printed forms to 1-888-436-8320, or email them to **CAIRHelpDesk@cdph.ca.gov.**

For more information, contact the CAIR Help Desk at 800-578-7889 or **CAIRHelpDesk@cdph.ca.gov**