Dear Patient,

Welcome to the Shasta Community Maternity Center. We are glad you chose us for your obstetric (OB) care. Our wish is to provide you with the best service possible. We hope you find the information below useful.

**Our Phone:** Please call (530) 225-7480 during our regular phone hours. These hours are 8 a.m. to 5 p.m. An after hours nurse can be reached at this same number 24 hours a day, holidays and weekends.

**Our Address:** 1900 Railroad Ave., Redding CA 96001

**Our Hours:** We are open Monday through Thursday from 8 a.m. to 5 p.m. We are closed on Friday, Saturday, Sunday, and all major holidays.

Please be aware that we are not a walk-in clinic and do not provide face-to-face, after-hours services. If you have an urgent, non-pregnancy related concern go to the nearest Emergency Room. **If you think you are in labor, contact Mercy Labor and Delivery at (530) 225-7380.**

**Appointments:** Appointments can be made by calling our main number, (530) 225-7480. Please arrive 15 minutes before your visit to complete your paperwork. Patients will be taken in order of their appointment times, not the order of arrival.

- **Late:** If you are late we may need to reschedule your visit. Please call in advance if you can’t make it on time. This will help us to see other patients that need our care.

- **Problem or Work-In:** Please do not walk-in. Call us first so we can see what days and times are best for your visit. Please be kind and know that you may need to wait. We will do our best to fit you into the schedule.

- **No Show:** Everyone’s time is valuable and appointment times are limited. If you need to cancel please let us know as soon as possible. We will need at least 2 hours notice prior to your visit. You can leave a message with the answering service. If you miss your visit without letting us know, you will get a letter of warning from our center manager. If you have barriers that keep you from getting to your visit, let us know so we can help.

**Smoking:** There is NO smoking allowed on our campus, including e-cigarettes.
Visitors and Children: We are sensitive to the needs of all of our patients and their privacy. For this reason no visitors will be allowed into the triage area. Also, only one person will be allowed in the exam room with you.

Please attend to your children at all times. No running, climbing, or rough play is allowed. We have children’s books available so that you can read with your child during wait times.

Thank you for choosing us for your OB care. We look forward to seeing you at the Center and will do our very best to make your visit as pleasant and efficient as possible.

Sincerely,

Shasta Community Maternity Center
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.
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.

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.

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:

  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.
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://sacvalleymso.org/](http://sacvalleymso.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.

**Consent to Text Messaging 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
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) 246-5858
privacy@shastahealth.org
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) 246-5858 or by email at privacy@shastahealth.org.

I acknowledge receipt of the “Notice of Privacy Practices” of SCHC.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign Here:</td>
<td></td>
</tr>
</tbody>
</table>

Relationship: □ Patient □ Parent □ Guardian/Legal Representative

If signing for the patient, print your name:
Shasta Community Health Center is committed to providing high-quality, cost-effective health care to the people we serve. We believe that every patient deserves to be treated with respect, dignity, and concern. We will provide care regardless of race, creed, sex, national origin, or source of payment.

We consider you a partner in your health care. When you are well informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. Shasta Community Health Center encourages respect for the personal preferences and values of each individual. It is our goal to assure that your rights as a patient are observed and to act as a partner in your decision making process.

While you are a patient at Shasta Community Health Center, you have the following rights:

**Access to Care**
- To exercise these rights without regard to gender, sexual orientation, culture, economics, education, religion, language, age, race, color, ancestry, national origin, presence of a disability, or the source of payment for your care.
- To obtain a reasonable response to any reasonable request made for services within the Health Center’s capacity, stated mission, applicable laws, and regulations. The Health Center will give each patient necessary health services to the best of its ability, including choice of clinician.
- To appropriate access to emergency services.

**Considerate and Respectful Care**
- To considerate, respectful care and treatment that optimizes your comfort and dignity.
- To appropriate care which reflects your desires, or that of a legal representative (surrogate decision maker), while acknowledging physical limitations, psychosocial, spiritual, and cultural concerns.
- To reasonable continuity of care and knowledge in advance of the time and location of future appointments, as well as the identity of the persons providing that care.

**Knowledge and Information**
- To have knowledge of the name of the clinician who has primary responsibility for coordinating your care and the names and professional relationships of other health professionals who will see you.
- To receive information from the clinician about your care and treatment in terms that you can understand.
- To receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment.

**Active Participation in Your Care**
- To actively participate with your clinician in making decisions regarding your care. Your designated representative also has this right.
- To formulate advance directives.
✓ **Privacy and Confidentiality**
  - To full consideration of privacy concerning your care and treatment. Your visit, discussion, consultation, examination and treatment are confidential and will be conducted discreetly.
  - To confidential treatment of all information, communications, and records pertaining to your care and treatment. Written permission from you or your legally designated representative shall be obtained before medical records can be made available to anyone not directly concerned with patient care. You or your legally designated representative are entitled to access the information contained in your medical record, within the limits of the law.

✓ **Respect for Patient Rights**
  - To express concerns or complaints about your care with the assurance that the presentation of a complaint will not compromise 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 Shasta Community Health Center personnel shall observe these patient rights and that all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on your behalf.
  - Receive information about Advanced Directives.

While you are a patient at Shasta Community Health Center, you have the following responsibilities:

✓ **Patient Responsibilities**
  - Provide your doctor with accurate and complete health information
  - Let your doctor know that you understand the medical procedures and what you are expected to do.
  - Be considerate and respectful of others, both patients and staff.
  - If you do not follow your clinician’s plan or if you refuse treatment, you must accept responsibility for your actions.
**Personal Information:** Give us some details about the patient so we can get to know them better.

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name: ______________________</td>
</tr>
<tr>
<td>First Name: _____________________</td>
</tr>
<tr>
<td>Middle Initial: ______</td>
</tr>
<tr>
<td>Date of Birth: __________________</td>
</tr>
<tr>
<td>Social Security #: ______________</td>
</tr>
<tr>
<td>Gender at Birth: Male □ Female □</td>
</tr>
<tr>
<td>Mailing Address: ______________________________________________________________________________________</td>
</tr>
<tr>
<td>City: ____________________________</td>
</tr>
<tr>
<td>State: _______    Zip Code: _____________</td>
</tr>
<tr>
<td>Physical Address (if different): ______________________________________________________________________</td>
</tr>
<tr>
<td>City: ____________________________</td>
</tr>
<tr>
<td>State: _______    Zip Code: _____________</td>
</tr>
<tr>
<td>Home Phone: ______________________</td>
</tr>
<tr>
<td>Work Phone: _____________________________</td>
</tr>
<tr>
<td>Cell Phone: __________________________    Email Address: _______________________________________________</td>
</tr>
<tr>
<td>Are you a veteran? Yes □ No □</td>
</tr>
<tr>
<td>Are you Hispanic? Yes □ No □</td>
</tr>
<tr>
<td>Are you homeless or at risk of being homeless? Yes □ No □</td>
</tr>
<tr>
<td>Race? (Check all that apply):</td>
</tr>
<tr>
<td>White □ Black/African American □ Asian □ Pacific Islander □ Native Hawaiian □ American Indian/Alaskan Native □ Don’t know or don’t want to say</td>
</tr>
<tr>
<td>What language do you prefer?</td>
</tr>
<tr>
<td>English □ ASL □ Spanish (Español) □ Mien (Mienh) □ Other: ________________</td>
</tr>
<tr>
<td>Would you like to have an interpreter during your medical visits? Yes □ No □</td>
</tr>
</tbody>
</table>

**Parent/Legal Guardian Information**  
*Only needed if patient is under 18*

<table>
<thead>
<tr>
<th>Parent/Legal Guardian Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Legal Guardian #1: ______________________________</td>
</tr>
<tr>
<td>Birthdate: ____________________</td>
</tr>
<tr>
<td>Type of Parent: □ Biological □ Adoptive □ Foster □ Other: ________________</td>
</tr>
</tbody>
</table>
| Parent/Legal Guardian #2: ______________________________
| Birthdate: ____________________|
| Type of Parent: □ Biological □ Adoptive □ Foster □ Other: ________________|
Emergency Contact: Let us know who to call if there’s an emergency.

Name: ___________________________ Relationship: ___________________________

Home Phone: ______________________ Cell Phone: ___________________________

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?

□ 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: ____________
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.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

☐ Sign Here:

<table>
<thead>
<tr>
<th>Relationship:</th>
<th>Patient</th>
<th>Parent</th>
<th>Guardian/Legal Representative</th>
</tr>
</thead>
</table>

If signing for the patient, print your name:
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

---

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Sign Here:**

- Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative

If signing for the patient, print your name:
# New Patient Questions

Name: _____________________________________________________

Date of Birth: ______________________________________________

1. Do you have any cardiac (heart) issues?  □ Yes  □ No
   □ [Question]

2. Do you have high blood pressure?  □ Yes  □ No
   □ [Question]

3. Do you have diabetes?  □ Yes  □ No
   □ [Question]

4. Have you had a recent stroke?  □ Yes  □ No
   □ [Question]

5. Do you have any lung or breathing problems?  □ Yes  □ No
   □ [Question]

6. Have you or anyone in your family ever had cancer?  □ Yes  □ No
   □ [Question]

7. Have you had any seizures?  □ Yes  □ No
   □ [Question]

8. Have you had any diseases of the liver?  □ Yes  □ No
   □ [Question]

9. Have you had surgery, been hospitalized, or gone to the emergency room within the last two months?  □ Yes  □ No
   □ [Question]

10. How many prescription medications do you take?  □ 0  □ 1-5  □ 6-10  □ 11 or more
    □ [Question]

11. What are your prescription medications and when are you going to run out of them?
    
    Example: Atenolol 1 week
    
    □ [Question]

12. Do you have a condition that causes you daily pain?  □ Yes  □ No
    □ [Question]

13. If yes, are you taking prescription pain medications?  □ Yes  □ No
    □ [Question]

14. How soon do you feel that you need to be seen and why?
    □ [Question]

15. Have you had a specialty care such as cardiology, neurology, psychiatry, etc.?  □ Yes  □ No
    □ [Question]

16. If yes, what kind of care?
    □ [Question]
Maternity 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.

<table>
<thead>
<tr>
<th>Medicine or Food</th>
<th>What happens when you take or eat it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: <em>amoxicillin</em></td>
<td><em>I break out in hives.</em></td>
</tr>
<tr>
<td>Example: <em>peanuts</em></td>
<td><em>I can’t breathe.</em></td>
</tr>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>

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

- □ Diabetes  Type: ________________________________
- □ Blood transfusion

- □ High blood pressure

- □ Heart problems  Type: ________________________________

- □ Autoimmune disorder  Type: ________________________________

- □ Kidney disease / urinary tract problems  Type: ________________________________

- □ Epilepsy / seizure disorder

- □ Mental health problems / anxiety

- □ Depression / postpartum depression  Type: ________________________________

- □ Hepatitis / liver disease  Type: ________________________________

- □ Anemia / blood disorder  Type: ________________________________

- □ Thyroid disease

- □ Trauma / violence

- □ Other: ________________________________

- □ Other: ________________________________

Medicine or Food What happens when you take or eat it?

Example: *amoxicillin*  I break out in hives.
Example: *peanuts*  I can’t breathe.

- □ Women’s health problems  Type: ________________________________

- □ HIV/AIDS

- □ Stomach or bowel problems / constipation  Type: ________________________________

- □ Other: ________________________________

- □ Other: ________________________________
### 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?

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother</strong></td>
<td></td>
</tr>
<tr>
<td>Alive</td>
<td>□ Heart problems</td>
</tr>
<tr>
<td></td>
<td>□ High cholesterol</td>
</tr>
<tr>
<td></td>
<td>□ Cancer, type:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Passed</td>
<td>□ Genetic disorder (runs in family)</td>
</tr>
<tr>
<td>Age: ________</td>
<td></td>
</tr>
</tbody>
</table>

| **Father**    |                   |
| Alive         | □ Heart problems  | □ Stroke          |
|               | □ High cholesterol| □ Mental illness  |
|               | □ Cancer, type:   | □ High blood pressure |
|               |                   | □ Alcohol/drug abuse |
| Passed        | □ Genetic disorder (runs in family) | □ Other: |
| Age: ________ |                   |                   |

| **Sister(s)** |                   |
| # Alive: ______ |
| # Passed: ______ |
| Age(s): ________ |
| # Heart problems | □ Stroke          |
|                | □ High blood pressure |
|                | □ Alcohol/drug abuse |
| # High cholesterol | □ Mental illness |
| # Cancer, type: | □ Other: |
| # Genetic disorder (runs in family) |

| **Brother(s)** |                   |
| # Alive: ______ |
| # Passed: ______ |
| Age(s): ________ |
| # Heart problems | □ Stroke          |
| # High blood pressure |
| # High cholesterol | □ Mental illness |
| # Alcohol/drug abuse |
| # Cancer, type: | □ Other: |
| # Genetic disorder (runs in family) |

| **Grandmother(s)** |                   |
| Alive | □ Heart problems  | □ Stroke          |
| Passed | □ High blood pressure |
|        | □ Alcohol/drug abuse |
|        | □ High cholesterol | □ Mental illness  |
|        | □ Cancer, type:   |
|        | □ Genetic disorder (runs in family) |
|        | □ Other: |

| **Grandfather(s)** |                   |
| Alive | □ Heart problems  | □ Stroke          |
| Passed | □ High blood pressure |
|        | □ Alcohol/drug abuse |
|        | □ High cholesterol | □ Mental illness  |
|        | □ Cancer, type:   |
|        | □ Genetic disorder (runs in family) |
|        | □ Other: |

*Please specify if on mother’s or father’s side by writing “M” or “F” next to condition.*
**MRN:** _________  
**Employee ID #:** _________  

## Social History:

<table>
<thead>
<tr>
<th>Current Employment Status</th>
<th>Alcohol Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Work, full-time</td>
<td>☐ Work, part-time</td>
</tr>
<tr>
<td>☐ Self-employed</td>
<td>☐ Unemployed</td>
</tr>
<tr>
<td>☐ Retired</td>
<td>☐ Disabled</td>
</tr>
<tr>
<td>☐ Other:</td>
<td>☐ Other:</td>
</tr>
</tbody>
</table>

→ Current job? ________________________________
→ Past job? ________________________________

<table>
<thead>
<tr>
<th>Type:</th>
<th>Former - Year Quit: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Beer</td>
<td>☐ Hard liquor</td>
</tr>
<tr>
<td>☐ Wine</td>
<td>☐ Other: ________</td>
</tr>
</tbody>
</table>

→ 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?

<table>
<thead>
<tr>
<th>Shot</th>
<th>Date:</th>
<th>Have the record?</th>
<th>☐ No  ☐ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Flu</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Hepatitis A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Hepatitis B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Pneumonia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Tetanus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Tuberculosis Skin Test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Shingles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Whooping Cough</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medications:

Please list all current medications (pills, inhalers, creams, patches). This includes over the counter medications, vitamins, and supplements.

<table>
<thead>
<tr>
<th>Name of the Medicine</th>
<th>Dose (include strength &amp; number of pills per day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: aspirin</td>
<td>81 mg tablet once daily</td>
</tr>
</tbody>
</table>
### Reproductive Health History:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a sexually transmitted disease (STD)?</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>→ If yes, what kind?</td>
<td></td>
</tr>
<tr>
<td>When was the first day of your last menstrual period?</td>
<td>Date: __________</td>
</tr>
<tr>
<td>How old were you when you started having periods?</td>
<td>Age: __________</td>
</tr>
<tr>
<td>Are you currently pregnant?</td>
<td>□ No □ Yes □ Maybe</td>
</tr>
<tr>
<td>Did you have a home pregnancy test? If yes, date of test: ______________</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Have you received any prenatal care for this pregnancy?</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Have you had any hospital visits since your last menstrual period?</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>→ If yes, when and where?</td>
<td></td>
</tr>
<tr>
<td>Have you had any sonograms?</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>→ If yes, when and where?</td>
<td></td>
</tr>
<tr>
<td>Have you had a pap smear?</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>→ If yes, when and where?</td>
<td></td>
</tr>
<tr>
<td>→ If yes, was it abnormal?</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>→ If yes, did you have any treatment? □ Cone □ Biopsy □ Colpo □ Other:</td>
<td></td>
</tr>
</tbody>
</table>

### Prenatal Health History: Please give us some more information about yourself.

<table>
<thead>
<tr>
<th>Your Race / Ethnicity:</th>
<th>Your Place of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Father of Child:</td>
</tr>
<tr>
<td></td>
<td>(Please list name and age)</td>
</tr>
</tbody>
</table>

| Language Spoken:       |                        |
|                       |                        |

<table>
<thead>
<tr>
<th>Do you have any birth defects? If yes, please list:</th>
<th>□ No □ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the baby’s father have any birth defects? If yes, please list:</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>To the best of your knowledge, do any of your blood relatives, or the father of the child’s blood relatives have any birth defects? If yes, please list:</td>
<td>□ No □ Yes</td>
</tr>
</tbody>
</table>
**Pregnancy History:** Please list all pregnancies, regardless of outcome (for example, live birth, stillbirth, ectopic pregnancy, miscarriage, or abortion). List in order of first pregnancy to most recent pregnancy. Examples of complications include gestational diabetes, high blood pressure, or NICU admission.

<table>
<thead>
<tr>
<th>Outcome of pregnancy</th>
<th>Delivery date or end of pregnancy</th>
<th>Pregnancy week at birth</th>
<th>Type of delivery</th>
<th>Baby’s name</th>
<th>Baby’s weight</th>
<th>Baby’s sex</th>
<th>Type of anesthesia (pain medication)</th>
<th>List any complications (Mom or Baby)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: live birth</td>
<td>6/3/20</td>
<td>38</td>
<td>C-section</td>
<td>Charlotte</td>
<td>7.4 lbs.</td>
<td>F</td>
<td>epidural</td>
<td>gestational diabetes, preeclampsia</td>
</tr>
</tbody>
</table>

**Sign Here:**

<table>
<thead>
<tr>
<th>Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative</th>
<th>Date:</th>
<th>Patient Name:</th>
</tr>
</thead>
</table>

If signing for the patient, print your name:
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?
This form is not required. 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 someone you choose as your caregiver, next of kin, or emergency contact. A caregiver may be someone such as a relative, close friend, or home care aide who brings you to our center. This person may also talk about your care with a clinician or other member of the care team. In cases where it may not be clear to us that you rely on someone as a caregiver, you may wish to tell us by listing them on the lines below. Also, even if they are not listed below, we may need to use our professional judgment 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:  | □ Next of Kin | □ Emergency Contact | □ Caregiver |

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

Patient Information:

| Patient Name: | Date: |
| Sign Here: |
| Relationship:  | □ Patient | □ Parent | □ Guardian/Legal Representative |

If signing for the patient, print your name:
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.

<table>
<thead>
<tr>
<th>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 required at the time of service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must complete the financial information form every year to determine your eligibility and discount. This information includes:</td>
</tr>
<tr>
<td>✓ Your total household income from all sources before taxes.</td>
</tr>
<tr>
<td>✓ Number of household members living in your household.</td>
</tr>
<tr>
<td>✓ 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.</td>
</tr>
</tbody>
</table>

Your discount may vary if your income changes.

- Sliding Fee Discount payments are 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.

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

Special Procedures:
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.
**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 Home**

*People who share all money made and bills - children too*

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
</tr>
<tr>
<td>2)</td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td></td>
</tr>
<tr>
<td>4)</td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td></td>
</tr>
<tr>
<td>6)</td>
<td></td>
</tr>
<tr>
<td>7)</td>
<td></td>
</tr>
<tr>
<td>8)</td>
<td></td>
</tr>
<tr>
<td>9)</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>How much money is made from all jobs? (A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Monthly $ ____________</td>
</tr>
<tr>
<td>□ Weekly $ ______________</td>
</tr>
<tr>
<td>□ Every 2 Weeks $ ________________</td>
</tr>
<tr>
<td>□ Twice a Month $ ________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Sources of Money</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Support/Alimony</td>
<td>$</td>
</tr>
<tr>
<td>Unemployment</td>
<td>$</td>
</tr>
<tr>
<td>Disability/Workers Comp</td>
<td>$</td>
</tr>
<tr>
<td>Interest/Dividends</td>
<td>$</td>
</tr>
<tr>
<td>Social Security/SSI/Survivors Benefits</td>
<td>$</td>
</tr>
<tr>
<td>Pensions</td>
<td>$</td>
</tr>
<tr>
<td>Rental Income</td>
<td>$</td>
</tr>
<tr>
<td>Public Assistance (not food stamps)</td>
<td>$</td>
</tr>
<tr>
<td>Education Assistance</td>
<td>$</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Household size:</th>
<th>Monthly Income:</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______________</td>
<td>Wages (A*): $</td>
</tr>
<tr>
<td></td>
<td>Other (B): $</td>
</tr>
<tr>
<td></td>
<td>TOTAL: $</td>
</tr>
<tr>
<td></td>
<td>(A* + B)</td>
</tr>
</tbody>
</table>

Category: ____________________________

Fee: $ ____________

Total Annual Income: $ ________________

Reviewed By: ________________________ O&E Referral: ______________ Renewal Date: _____________
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.
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:
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!

Note: The blue and white card is available to all patients. The orange 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:**

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>Location Details</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cottonwood Drugs</strong></td>
<td>20635 Gas Point Rd., Cottonwood</td>
<td>(530) 347-3721</td>
</tr>
<tr>
<td><strong>CVS Pharmacy</strong></td>
<td>1060 E. Cypress Ave., Redding</td>
<td>(530) 221-5575</td>
</tr>
<tr>
<td></td>
<td>3375 Placer St., Redding</td>
<td>(530) 241-7328</td>
</tr>
<tr>
<td></td>
<td>1035 Placer St., Ste. 110, Redding</td>
<td>(530) 999-6073</td>
</tr>
<tr>
<td></td>
<td>2025 Court St., Ste. A, Redding</td>
<td>(530) 999-6072</td>
</tr>
<tr>
<td></td>
<td>317 Lake Blvd., Ste. B, Redding</td>
<td>(530) 999-6099</td>
</tr>
<tr>
<td></td>
<td>1280 Dana Dr., Redding (Inside Target)</td>
<td>(530) 224-1437</td>
</tr>
<tr>
<td></td>
<td>2975 East St., Anderson</td>
<td>(530) 744-6024</td>
</tr>
<tr>
<td></td>
<td>455 S. Main St., Red Bluff</td>
<td>(530) 529-5530</td>
</tr>
<tr>
<td></td>
<td>1311 S. Main St., Weaverville, CA</td>
<td>(530) 623-5555</td>
</tr>
<tr>
<td><strong>Raley's</strong></td>
<td>201 Lake Blvd., Redding</td>
<td>(530) 246-3511</td>
</tr>
<tr>
<td><strong>Safeway Pharmacy</strong></td>
<td>2275 Pine St., Redding</td>
<td>(530) 247-3040</td>
</tr>
<tr>
<td></td>
<td>1070 E. Cypress Ave., Redding</td>
<td>(530) 222-8274</td>
</tr>
<tr>
<td></td>
<td>2601 Balls Ferry Rd., Anderson</td>
<td>(530) 365-1010</td>
</tr>
<tr>
<td><strong>Walgreens Pharmacy</strong></td>
<td>980 E. Cypress Ave., Redding</td>
<td>(530) 221-5028</td>
</tr>
<tr>
<td></td>
<td>1775 Eureka Way, Redding</td>
<td>(530) 241-3294</td>
</tr>
<tr>
<td></td>
<td>115 Lake Blvd., Redding</td>
<td>(530) 229-1519</td>
</tr>
</tbody>
</table>

The pharmacies shown below are in our network, but **do not** offer a 340B discount. **Patients who have insurance** will be supporting SCHC.

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>Location Details</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rite Aid Pharmacy</strong></td>
<td>3095 McMurray Dr., Anderson</td>
<td>(530) 365-5753</td>
</tr>
<tr>
<td></td>
<td>975 East Cypress Ave., Redding</td>
<td>(530) 223-3995</td>
</tr>
<tr>
<td></td>
<td>6424 Westside Rd., Redding</td>
<td>(530) 243-3616</td>
</tr>
<tr>
<td></td>
<td>1801 Eureka Way, Redding</td>
<td>(530) 243-5500</td>
</tr>
<tr>
<td></td>
<td>5350 Shasta Dam Blvd., Shasta Lake</td>
<td>(530) 275-1532</td>
</tr>
<tr>
<td><strong>Wal-Mart Pharmacy</strong></td>
<td>5000 Rhonda Rd., Anderson</td>
<td>(530) 378-1680</td>
</tr>
<tr>
<td></td>
<td>1515 Dana Dr., Redding</td>
<td>(530) 221-3166</td>
</tr>
</tbody>
</table>
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 your 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 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.

To implement Public Law 101-508, the California Consortium on Patient Self-Determination prepared this brochure in 1991; it was revised in 2000 by the California Department of Health Services, with input from members of the consortium and other interested parties, to reflect changes in state law.
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
- Prevent disease in your community
- Remind you about shots needed
- 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

California Department of Public Health 850 Marina Bay Pkwy, Bldg P Richmond, CA 94804
Med Office IZ Registry Disclosure Letter

IMM-891E (11/19)