REGISTRATION FORM

** Please print all information*

X: ____ CHART #: ____

TRI-CITY **HealthCenter**

Our Community. Your Health.

TODAY'S DATE: ____

FAMILY SIZE : ____

MONTHLY INCOME: ____

* If this is a child (,< than 18 yo) please indicate the person who we can contact in case of emergency.

INTERPRETER NEEDED?: ☐ YES ☐ NO

Parent / Guardian: ____ Phone # ____

Patient Information

LAST NAME : ____ FIRST NAME : ____ M. INITIAL : ____

BIRTHDATE : ____ SOCIAL SECURITY # ____ SEX ☐ M ☐ F

HOME ADDRESS: ____ CITY: ____ ZIP CODE: ____

E-MAIL ADDRESS: ____ EMPLOYER: ____

Preferred Contact Method: ☐ Email ☐ Home # ☐ Cell # ☐ Work #

HOME PHONE: ____ CELL PHONE: ____ Work PHONE: ____

ETHNICITY:

- ☐ Afghani
- ☐ African American
- ☐ Asian
- ☐ East Indian
- ☐ European
- ☐ Hawaiian Native
- ☐ Filipino
- ☐ Hispanic / Latino
- ☐ Indochinese
- ☐ Middle Eastern
- ☐ Native American
- ☐ Pakistani
- ☐ Pacific Islander
- ☐ Undeclared

Other ____

RACE:

- ☐ White
- ☐ Asian
- ☐ African American
- ☐ Native American
- ☐ Black
- ☐ Alaska Native
- ☐ Pacific Islander
- ☐ Undeclared

Other ____

LANGUAGE:

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Mien
- ☐ Laos
- ☐ Vietnamese
- ☐ Cambodian
- ☐ Tagalog
- ☐ Tigrinya
- ☐ Amharic
- ☐ French
- ☐ Arabic
- ☐ Hindi / Urdu

Other ____

Unknown ____

MARITAL STATUS: ____

Do you consider yourself to be homeless?

☐ YES ☐ NO

If you're homeless, are you living in a shelter?

☐ YES ☐ NO

HEALTH ACCESS PROGRAMS
FAMILY PACT PROGRAM
CLIENT ELIGIBILITY CERTIFICATION (CEC)

Client identification number

This form is the property of the State of California, California Department of Public Health, Office of Family Planning, and cannot be changed or altered.

Please ***print*** answers to all questions. The questions about your family size, income, and health care insurance are to determine if you are eligible for Family PACT Program services.

- Providers must keep a copy of this form in the client's medical record. (See PPBI, Client Eligibility Certification Form Completion Section for code determinations.)
- ***Code areas are for Provider use only***.

Do you currently receive Medi-Cal benefits or services? ☐ Yes ☐ No

Do you have a Medi-Cal Benefits Identification Card (BIC)? ☐ Yes ☐ No

BIC number	Issue date

Do you have health care insurance for family planning services? (Private insurance, Health Maintenance Organization (HMO), Managed Care Plan, Student Health Insurance, etc.) ☐ Yes ☐ No

Do we need to keep your family planning services confidential from your partner, spouse, or parent? How may we contact you if we need to talk to you about something? ☐ Yes ☐ No *Confidentiality* — *Provider Use Only*—**CODE**

First name	Middle name	Last name	Suffix (Jr., Sr.)

Is your current name the same as your name at birth? If no, print your name at birth below. ☐ Yes ☐ No

First name at birth	Middle name at birth	Last name at birth	Suffix (Jr., Sr.)

Number of live births	County of residence	*Provider Use Only*—**CODE**	Nine-digit ZIP code

Gender ☐ Male ☐ Female	*Provider Use Only*—**CODE**	Social security number	Mother's first name

Date of birth (mm/dd/yyyy) / /_ _ _ _	Place of birth (county, if California)	*Provider Use Only*—**CODE**	State (if not California)	*Provider Use Only*—**CODE**	Country (if not USA)	*Provider Use Only*—**CODE**

Race/ethnicity

1 ☐ Asian 2 ☐ Black 3 ☐ Filipino 4 ☐ Hispanic
5 ☐ Native American 6 ☐ Pacific Islander 7 ☐ White 0 ☐ Other

Primary Language

1 ☐ Armenian 2 ☐ Cantonese 3 ☐ English 4 ☐ Hmong 5 ☐ Khmer/Cambodian
6 ☐ Korean 7 ☐ Tagalog 8 ☐ Spanish 9 ☐ Vietnamese 0 ☐ Other

This information will be used to see if you are enrolled in any state health program. Information will also be used to monitor health outcomes and for program evaluation purposes. Your name will not be shared. Each individual has the right to review personal information maintained by the provider unless exempt under Article 8 of the Information Practices Act.

Complete eligibility information on reverse side.

Eligibility Determination: Please list all family members (self, spouse, and children) living in your household and supported by the family income. List the source of any earned or unearned income and the amount of income, including income from employment, self-employment, tips, commissions, pensions, social security, child and/or spousal support, ongoing insurance payments, disability, Veterans Affairs, unemployment benefits, etc.

Name	Relationship to You	Age	Source of Income	Gross Monthly Income (Before taxes or deductions.)
	(Self)			
Family size:			Total family income	$

I declare under penalty of perjury that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for this program.

Signature (or mark) of applicant	Date	Signature of witness to mark or interpreter	Date

FOR PROVIDER USE ONLY

Provider certification: ☐ Eligible for Family PACT Program
☐ Ineligible for Family PACT Program (Give applicant Fair Hearing Rights.)

Medi-Cal client eligible for Family PACT verified: ☐ Limited scope ☐ Unmet share-of-cost

Based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this Client Eligibility Certification is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of this form which includes the Fair Hearing Rights.

Print name	Signature	Date

Annual Certification: If client is decertified (no longer eligible)	Date	Reason code (see Provider Manual)

Fair Hearing Rights

Any applicant for, or recipient of, services under the Family PACT Program has a right to a hearing conducted by the California Department of Public Health regarding eligibility or receipt of services. An applicant or recipient does not have a right to contest changes made to the eligibility standards or benefits of the Family PACT Program.

First level review: If you wish to appeal either your denial of eligibility or receipt of services, please send your name, telephone number, address, and reason why you are requesting a review to the **First Level Review address** below. A request for a first level review must be postmarked within 20 working days of the denial of eligibility or services. The Office of Family Planning may request additional information by telephone or in writing from the provider or the applicant before issuing a decision.

Formal hearing: You may appeal the decision of the first level review within five working days of your receipt of the decision of the first level review by sending your name, telephone number, address, and reason for the appeal to the **Formal Hearing address** below. At the hearing, you may be represented by a friend, relative, lawyer, or other person of your choice. A representative of the provider will be present to explain the reasons for denying eligibility. If you want an interpreter provided at the hearing, please specify the language in your letter requesting a hearing.

First Level Review

California Department of Public Health
Office of Family Planning
MS 8400
P.O. Box 997420
Sacramento, CA 95899-7420

Formal Hearing

California Department of Public Health
Office of Regulations and Hearings
MS 0507
P.O. Box 997377
Sacramento, CA 95899-7377

"STAYING HEALTHY" ASSESSMENT
Adults, 18 years of age and older

Patient Stamp

Patient Number ______ Plan Name/Number ______

If patient stamp not used, write in Patient and Plan Name/Number

Patient's name (first, last)	Date of birth	Sex	Today's date	***For Clinical Use***
		❐ Male ❐ Female		**Assistance needed:** **Reading:** ❐ Yes ❐ No **Interpreter:** ❐ Yes ❐ No

Annual Review Date/Initials

You and your health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.

Sample Question and Answer: Do you play sports? ✔Yes No Skip

Interventions Code/Date/Initials

Do You:

#	Question			
1.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip
2.	See the dentist at least once a year?	Yes	No	Skip
3.	Drink milk or eat yogurt or cheese at least 3 times each day?	Yes	No	Skip
4.	Eat fruits and vegetables every day?	Yes	No	Skip
5.	Try to limit the amount of fried or fast foods that you eat?	Yes	No	Skip
6.	Exercise or do moderate physical activity such as walking or gardening 5 days a week?	Yes	No	Skip
7.	Think you need to lose or gain weight?	No	Yes	Skip
8.	Often feel sad, down, or hopeless?	No	Yes	Skip
9.	Have friends or family members that smoke in your home?	No	Yes	Skip
10.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.				***For Clinical Use*** **Interventions Code/Date/Initials**
Do You:				
11. Smoke cigarettes or cigars or use any other kinds of tobacco?	No	Yes	Skip	
12. Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
13. Often have more than 2 drinks containing alcohol in one day?	No	Yes	Skip	
14. Think you or your partner could be pregnant?	No	Yes	Skip	
15. Think you or your partner could have a sexually transmitted disease?	No	Yes	Skip	
Have You:				
16. Or your partner(s) had sex without using birth control in the last year?	No	Yes	Skip	
17. Or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
18. Or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
19. Ever been forced or pressured to have sex?	No	Yes	Skip	
20. Ever been hit, slapped, kicked, or physically hurt by someone?	No	Yes	Skip	
21. **Do you have other questions or concerns about your health?** (Please identify) ______________________ ______________________ ______________________ ______________________	No	Yes	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

Privacy Statement

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contracted health plans, and health care providers.

LABEL

TRI-CITY HealthCenter
Our Community. Your Health.

Adult Health History Questionnaire

REASON FOR VISIT: List in order of importance to you	MEDICINES: List all meds, herbs, nutritional supplements
ALLERGIES: List any allergies to medications and / or foods	

PAST MEDICAL HISTORY: Do you have, or have you ever had in the past, any of the following conditions?
Check (✓) each box "yes" or "no" – no straight lines please. Complete BOTH columns

	NO	YES	Comments		NO	YES	Comments
high blood pressure				kidney / urine problems			
high cholesterol				stroke			
diabetes				cancer			specify:
heart problem /chest pain				prostate problems			
thyroid problems				arthritis / joint problems			
lung Problems / asthma				back problems			
breast problems				serious injuries			
eye / visual problems			☐ corrective lenses	severe headaches			
ear / hearing problems				convulsions / seizures			
seasonal allergies				anxiety/nervousness			
Stomach problems / ulcers				blood clots (leg / lung)			
hepatitis / liver problems				skin problems			
bowel problems/ colon polyp				depression			
hemorrhoids				other issues (please list)			
anemia / blood problems				Surgeries			
blood transfusions							

SURGERIES AND HOSPITALIZATIONS:

YEAR	ILLNESS / INJURY / SURGERY	HOSPITAL

FEMALES ONLY:

Age of first period?	**REPRODUCTIVE HISTORY:**
First day of last NORMAL period (LNMP):	Have you ever been pregnant? ☐ No ☐ Yes
Length of cycle? / Days of flow?	Total number of pregnancies: ______________
Periods are: ☐ regular ☐ irregular	a) # live births: ______ d) # still births: ____________
Maximum # pads / tampons used in 1 hour? ____________	b) # full term: ______ e) # miscarriages /abortions: _____
Menstrual cramps: ☐ none ☐ mild ☐ moderate ☐ severe	c) # premature: ______ f) # ectopic /tubal pregnancies ___
Date of last Pap Smear:__________ Was it normal? ☐ Yes ☐	Last Delivery Date: ________ Any problems? ☐ No ☐ Yes
Ever had an abnormal Pap Smear? ☐ No ☐ Yes	Number of children now living?
Date of last Mammogram: ________ Was it normal? ☐ Yes ☐	Are you breastfeeding now? ☐ No ☐ Yes

Did your mother take DES (a hormone) when she was pregnant with you? ☐ No ☐ Yes ☐ Unknown

TRI-CITY HealthCenter
Our Community. Your Health.

LABEL

Adult Health History Questionnaire

SYMPTOMS: Do you currently have any of the following symptoms? *Please complete BOTH columns.*

	NO	YES	Comments		NO	YES	Comments
Unusual heartbeat				lightheaded / dizzy / feeling faint			
Chest pains				trouble sleeping too little or too much?			
Night sweats				problems/ pain with sex			
Trouble breathing				Weakness			
Frequent cough				Little interest / pleasure doing things?			
Indigestion				Feeling down, depressed, hopeless?			
Abdominal pains				Very often feel moody, agitated overwhelmed			
Unusual weight gain / loss							
Constipation / diarrhea				Has anyone hurt or abused you? ☐ never ☐ recently ☐ in the past			
Trouble with urination				If yes, how? ☐ Physically ☐ Mentally ☐ Sexually			
Blood in stools or rectum				Do you currently feel safe at home? ☐ no ☐ yes ☐ sometimes			
Female-hot flashes				Any other symptoms:			

FAMILY HISTORY: Has any of your family / blood relatives ever had any of the following conditions? *Complete BOTH columns.*

	NO	YES	Comments		NO	YES	Comments
High blood pressure				Gastrointestinal problem			
Diabetes or high sugar				Hepatitis / Liver problem			
Heart problems				Alcohol / Drug problem			
Stroke				psychiatric/emotional problem			
Cancer				Inherited disorders			
TB or lung problems				Thalassemia or Sickle cell			
Kidney or urine problem				Any other problems in the family?			

SOCIAL HISTORY:

Marital Status: ☐ Dating ☐ Single ☐ Married /Significant Other ☐ Separated ☐ Divorced ☐ Widowed

Occupation:

Education: ☐ grade school ☐ high school ☐ some college ☐ college degree ☐ graduate school

HABITS:

Do you need assistance for DAILY ACTIVITIES? ☐ No ☐ Yes If yes, please check from the following needs:
☐ Cooking ☐ Grocery shopping ☐ Dressing ☐ Bed ☐ Using Toilet ☐ Getting up from a chair ☐ Taking medications

DO YOU NOW USE, **OR HAVE YOU EVER USED**, the following:

Tobacco	☐ No	☐ Yes	Type? ______	# packs/day ______	# years? ______	Last use? ______
Alcohol	☐ No	☐ Yes	Type? ______	# drinks/day ______	# years? ______	Last use? ______
Street Drugs	☐ No	☐ Yes	Type? ______	# times/week?	# years? ______	Last use? ______

SEXUAL HISTORY:

☐ No sexual experience ever before ☐ Virgin (no previous intercourse) ☐ Not sexually active at this time
☐ Sexually active with (check all that apply): ☐ Men ☐ Women ☐ Both ☐ Paid for sex or Prostitute
Number of partners in last 12 months: ______
Most recent sexual relations was ______ months / years ago
Frequency of unprotected intercourse: ☐ never ☐ occasional ☐ often Most recent unprotected encounter:___weeks/months/years ago

Does your sexual partner have other sexual partners? ☐ No ☐ Yes ☐ I don't know / maybe

Have you had a sexual partner who has had sex with: ☐ an IV drug user ☐ prostitute / paid for sex ☐ a person of the same sex

Have you OR your sexual partner(s) had any infections related to sex? ☐ No ☐ Yes (if yes, please specify):

LABEL

Adult Health History Questionnaire

BIRTH CONTROL METHODS:

What method of birth control are you using currently? ☐ none ☐ condoms ☐ pills ☐ injection ☐ IUD ☐ tubaligation ☐ other:________

Have any birth control methods caused you problems? ☐ No ☐ Yes, explain:

What birth control method have you used in the past? (Check all that apply) Men answer the first line, women any that apply.

☐ None ☐ Abstinence ☐ Rhythm method ☐ Withdrawal ☐ Condom ☐ Vasectomy

☐ Pill ☐ Patch ☐ DMPA (Depo) ☐ Norplant ☐ Diaphragm ☐ IUD

☐ Tubal Ligation ☐ Foam / vaginal insert ☐ Other (specify): ______________________________

EXERCISE

Do you exercise regularly? ☐ No ☐ Yes If yes, what type?________ How many minutes per

DIET:

Do you have, or have you ever had, an eating disorder or special eating problems? ☐ No ☐ Yes, explain:

Current Dietary Intake:	High	Medium	Low	Comments
Fat	☐	☐	☐	
Fiber (Fruit / Vegetables)	☐	☐	☐	
Caffeine	☐	☐	☐	
Salt	☐	☐	☐	
Sugar	☐	☐	☐	
Water / Fluids	☐	☐	☐	

IMMUNIZATIONS & TESTS:

What vaccinations do you know you have received in the past *as an adult or child*? (Please check)

☐ Td / Tetanus ☐ Polio ☐ MMR ☐ Rubella ☐ Pneumovax

☐ Influenza ☐ Hepatitis A ☐ Hepatitis B ☐ Varicella

Check here if you received your childhood vaccinations in the U.S. ☐ Check here if you have NOT had any vaccinations ☐

Most recent TB skin test?__________

Have you ever had a positive TB skin test? ☐ No ☐ Yes If yes, Chest X-ray result: ☐ Normal ☐ Abnormal

Have you ever been treated for TB? ☐ No ☐ Yes If yes, please answer the following:

Date of treatment: ________________ Name of medication: ________________ Length of treatment: _____months

This form was completed by: ☐ Myself, the *patient:* ______________________________ Today's date: ______________

☐ Staff: ______________________________ (name)

☐ Friend / Relative: ______________________________ (Name / Relation)

Date: ______________

Reviewed by:

☐ ______________________________ MD ☐ ______________________________ NP/PA

ANNUAL EXAM (HISTORY UPDATE AND REVIEW):

Signature:	Date:	Updates / Comments:
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		

LABEL

Adult Health History Questionnaire

MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		
MD / NP / PA		

TRI-CITY
HealthCenter

Our Community. Your Health.

LABEL

Consent for General Medical Services

I, ____, give my consent to Tri-City Health Center for any diagnostic procedures or medical treatment, including immunizations, considered to be necessary by the physician, nurse practitioner, physician assistant, or other medical providers of the clinic.

I authorize my insurance benefit to be paid directly to Tri-City Health Center. I understand I will be responsible for any services that are not covered under my insurance benefit.

I also authorize the release of any information necessary in the processing of any claims.

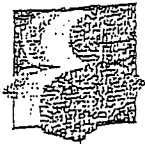
____ ____________________

Print Name of Patient Date

________________________________ ☐ If you are parent or legal guardian of patient.

Signature

6/2010



TRI-CITY HEALTH CENTER

I acknowledge that I have received a copy of Tri-City Health Center's Notice of Privacy Practices.

Reconozco recibir de una copia del Aviso sobre las Prácticas de Privacidad del Centro Médico.

我承認我已收到一份健康中心的隱私慣例通知。

본인은 건강센터(Health Center)의 Notice of Privacy Practices(사생활 보호 실행) 사본을 받았음을 인정합니다.

Tôi xác nhận rằng tôi đã nhận được một bản của Thông Cáo Về Lệ Lối Tôn Trọng Riêng Tư Cá Nhân của Trung Tâm Y Tế.

بدینوسیله وصول یک نسخه از آگهی رویه حفظ اطلاعات در مرکز درمانی را اعلام مینمایم.

Signature

Date

Print Name

Relationship to Patient

Comments:

Effective Date: April 14. 2003

TRI-CITY HEALTH CENTER
SUMMARY NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information.
Please Review It Carefully.

The following is a summary of Tri-City Health Center's Notice of Privacy Practices. If you have any questions about the Summary or the Notice, please contact the Privacy Officer at 510.770.8133 ext. 290.

Who Will Follow Our Notice:
Our Notice of Privacy Practice describes our health center's practices and that of:

- Any health care professional who provides services to you within our facilities.
- All sites, locations, departments and units of the health center.
- All employees, staff, consultants, volunteers and other health center personnel

We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you a notice of our legal duties and privacy practices
- Follow the terms of the notice, as currently in effect

Our Pledge Regarding Health Information:
We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive at the health center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the health center whether made by the health center personnel or your doctor.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. It also describes your rights with respect to your health information, and tells you how to exercise them.

How We May Use And Disclose Health Information About You:
We may use your health information to provide you with medical treatment, and to arrange and coordinate your health care; to obtain payment for our services; and to conduct our health care operations, including quality assurance, fundraising, and general management and administration. We may disclose your health information for a variety of purposes in the public interest, as required or permitted by law. We will obtain your written authorization to use or disclose your health information for other purposes.

Your Health Information Rights:
You have a right to inspect and copy your health information, and to request amendments to it. You also have a right to have an accounting of disclosures of your medical information. You have a right to request restrictions on the disclosure of health information to others. You have a right to confidential communications about your treatment or services.

♦ *This is a summary only; please read the attached notice carefully.* ♦

Effective Date: April 14, 2003

TRI-CITY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice contains a summary of our health information privacy practices and of your rights relating to your health information. In the absence of an express statement to the contrary, this notice is not intended to preclude or restrict uses or disclosures of health information that are otherwise permitted by law, or to give you rights that we are not required by law to give you.

If you have any questions about this notice, please contact the privacy officer at 510.770.8133 ext 290.

Who Will Follow This Notice:

This notice describes our health center's practices and that of:

- All employees, staff, and other health center personnel.
- All departments and units of the health center.
- Any independent health care professional who provides services to you within our facilities.
- Any member of a volunteer group we allow to help you while you are in the health center.

All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share medical information with each other for treatment, payment, or health center operations purposes described in this notice.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the health center. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of youı care maintained by the health center, whether made by the health center personnel or your personal doctor.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of this notice, as currently in effect.

How We May Use And Disclose Medical Information About You:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other health center personnel who are involved in taking care of you at the health center. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the health center also may share medical information about you in order to coordinate the different services you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the health center who may be involved in your medical care after you leave the health center, such as family members, social service agencies, health care facilities, and viders that we use to provide services for part of your care.

For Payment. We may use and disclose medical information about you to bill and collect payment from you or another source, such as an insurance company or a relative who has financial responsibility for you. For example, we may need to give your health plan information about medical care you received at the health center so your health plan will pay us or reimburse you for the medical care. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for health center operations, and in limited circumstances to enable the recipient of the information to carry out its operations. These uses and disclosures are necessary to run the health center and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical

information about many health center patients to decide what additional services the health center should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other health center personnel for review and learning purposes.

Quality of Care Improvement Activities. We may use and disclose medical information about you for reviews of the quality of care we are providing. For example, our health center works with the Community Health Center Network, a local group who has reviewed the quality of diabetes care being provided to patients in our area.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the health center.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that we provide and that may be of interest to you.

Fundraising Activities. We may use medical information about you to contact you in an effort to raise money for the health center and its operation. We may disclose medical information to a foundation related to the health center so that the foundation may contact you in raising money for the health center. We would only release contact information, such as your name, address and phone number. If you do not want the health center to contact you for fundraising efforts, you must notify the privacy officer in writing.

Payment for Your Care. We may also give information to someone who helps pay for your care.

Contractors. We may disclose your health information to our contractors who assist us with our operations. Our contractors agree in writing to keep the health information provided to them confidential and secure, and not to use it except to assist us.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. Where feasible, research information will not include information that could identify you as an individual. If research projects can identify you, those projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been

approved through this research approval process.

As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

For Public Health Activities. We may disclose health information about you for public health purposes, if we are required or permitted to do so by law. The following are examples of circumstances in which we may be mandated or permitted by law to make a report:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report the abuse or neglect of children, elders, and dependent adults;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to public health registries such as a breast cancer registry
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- to notify the appropriate authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special Situations

In addition to the practices described above, there are other situations in which we may be required or permitted to disclose our patients' health information. These include the following:

Disasters. We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Organ and Tissue Donation. If you are an organ donor or a prospective donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to

facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces or a veteran, we may release medical information about you as required by military command authorities or to assist in determining your eligibility for veterans' benefits. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities. We may disclose information to a health oversight agency for activities authorized by law. These oversight activities include, for example, Medi-Cal audits, investigations of Medicare claims, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you).

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the health center; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the health center to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We may also disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

De-Identified Information. We may remove information that identifies you from you health information, so others may use it without learning who you are. Once your health information has been de-identified, we may use or disclose it.

Limitations In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described above. For example, government health benefit programs may limit the disclosure of members' health information for purposes unrelated to the program. In addition, there are special restrictions on the disclosure of health information relating to HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

Your Rights Regarding Medical Information About You:

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.
To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the medical record department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the health center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the health center.

To request an amendment, your request must be made in writing and submitted to the medical record department. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the health center;
- Is not a part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, and disclosures you have authorized.

To request this list of accounting of disclosures, you must submit your request in writing to the medical record department. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a test you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the privacy officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing at time of registration. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to This Notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for all medical information we already have about you as well as any information we receive in the future. We will **post a copy of the current notice** in the health center. The notice will contain the effective date on the first page, in the top right-hand corner.

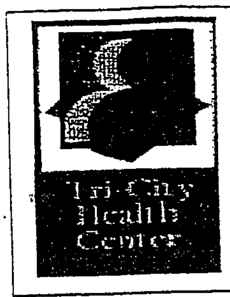
Complaints:

If you believe your privacy rights have been violated, you may file a complaint with the health center or with the Secretary of the Department of Health and Human Services. To file a complaint with the health center, contact the privacy officer at 510.770.8133 ext 290. All complaints must be submitted in writing.

We will not retaliate against you for filing a complaint.

Other Uses of Medical Information:

Other uses and disclosures of medical information not covered by this notice or otherwise permitted by the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.



Advance Health Care Directive
Fact Sheet for Consumers

What is an Advance Health Care Directive (AHCD)?
An AHCD is a way to make your health care wishes known if you are unable to speak for yourself or prefer someone else to speak for you. An AHCD can serve one or both of these functions:

- Power of Attorney for Health Care (to appoint an agent)
- Instructions for Health Care (to indicate your wishes).

Is the AHCD different from a Durable Power of Attorney for Health Care (DPAHC)?
The AHCD was enacted by July 2000 legislation and replaced the DPAHC and the Natural Death Act Declaration. However, if you had already completed one of these forms that was valid before July 1, 2000, it is still valid now. The only advance directive form that didn't change was the Pre-Hospital Do-Not-Resuscitate form.

"Pre-Hospital Do-Not-Resuscitate form?" Never heard of it!
This special form allows persons to indicate that they do not want CPR started if something happens to them outside a hospital. Normally, emergency medical personnel are required to start CPR for all persons; having this form protects people from CPR if they choose to forego it. This is the only form that must be signed in advance by your doctor.

I've never completed an "advance health care directive" before. Why should I?
Persons of all ages may unexpectedly be in a position where they cannot speak for themselves, such as an accident or severe illness. In these situations, having an "advance health care directive" assures that your doctor knows your wishes about the kind of care you want and/or who the person is that you want to make decisions on your behalf.

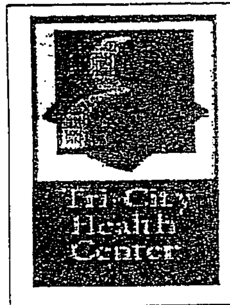
Does this mean only *one* person can decide for me? What if I want others involved, too?
Often many family members *are* involved in decision-making. And most of the time, that works well. But occasionally, people will disagree about the best course of action, so it is usually best to name just one person as the agent (with a back up, if you want). You can also indicate if there is someone who you do NOT want to make your decisions for you.

But I thought the doctors make all those life-and-death decisions anyway?
Actually, doctors tell you about your medical condition, the different treatment options that are available to you and what may happen with each type of treatment. Though doctors provide guidance, the decision to have a treatment, refuse a treatment or stop a treatment is yours.

What if something happens to me and no form has been completed?
If you are not able to speak for yourself, the doctor and health care team will turn to one or more family members or friends. The most appropriate decision-maker is the one with a close, caring relationship with you, is aware of your values and beliefs and is willing and able to make the needed decisions.

My "values and beliefs?" But I haven't talked with anyone about these!
That's why it is a good idea to talk with family or close friends about the things that are important to you regarding quality of life and how you would want to spend your last days and weeks. Knowing the things that are most important to you will help your loved ones make the best decisions.

June 9, 2009



Directivas de Salud (Advance Directives)—Sepa Sus Derechos

Diganos lo que desea sobre su cuidado médico:
Usted tiene el derecho de comunicar a sus proveedores de salud el tipo ó nivel de cuidados médicos que usted desea recibir en caso de no estar en condiciones de decircelo a nadie.

¿Qué es una directiva de salud (advance directive)?
Es un documento escrito legalmente que, en caso de que usted esté gravemente enfermo y no esté en condiciones de poder hablar, su proveedor de salud sabrá que tipo o nivel de cuidados médicos usted desea recibir en esa situación. La directiva de salud comunica a su proveedor médico el nivel de cuidados medicos que si desea y los que no desea. En esta directiva usted puede identificar a un familiar o amigo el cual usted quiere que ayude a hacer decisiones sobre su cuidado médico cuando usted esté incapacitado para hacerlo.

¿Cómo hago una directiva de salud?
La manera mas facil de hacer una directiva de salud es hablando con su proveedor médico y comunicándole sus deseos. Su proveedor(a) escribirá sus instrucciones. Esta información puede incluir el nombre de la persona que usted quiere que sea consultada acerca de su cuidado médico cuando usted esté incapacitado para hacerlo. (La persona que usted designe se le llamará su agente.) En su directiva de salud también puede identificar a las personas que usted no quiere que sean involucradas para hacer decisiones sobre su cuidado médico.

¿Porqué sería bueno para mi tener una directiva de salud?
Puede ser que algún dia usted se encuentre muy enfermo(a) o mal herido(a) sin poder tomar decisiones o sin poder decirle a nadie sus deseos acerca de sus cuidados médicos. Una directiva de salud hace saber a sus familiares y a su doctor sus deseos en caso de estar en peligro de muerte y asegura que sus deseos sean cumplidos. Una directiva de salud comunica a su proveedor médico cual es la persona o personas en que usted confia para hacer decisiones sobre su cuidado médico en caso que esté gravemente enfermo(a).

¿Qué pasa si yo quiero cambiar mi directiva en el futuro?
Las directivas de salud pueden ser cambiadas a cualquier hora, siempre y cuando le deje saber a alguien sus deseos. Puede cambiar las instrucciones en su directiva de salud cuando usted quiera, solamente necesita comunicar sus nuevos deseos a su proveedor médico. También puede remplazar a la persona que usted quiera que sea su "agente" en estos casos de emergencia médica.

¿Tengo que hacer una directiva de salud (advance directive)?
No, usted no está obligado a hacer una directiva de salud. Las directivas de salud se hacen voluntariamente. Su propósito es comunicar claramente a su familia y a sus proveedores médicos el tipo y nivel de cuidado medico que usted quiere recibir en situaciones cuando usted esté incapacitado(a) para comunicar sus propios deseos. Usted puede pedir ayuda de cualquier de sus proveedores de salud para redactar una directiva de salud cuando usted quiera. Sus proveedores médicos quieren y estan dispuestos a ayudarle en esto.