MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

FAMILY PRACTICE CLINIC

P: 530-708-8820
F: 530-233-4302

Please bring the following to your first appointment:

1.) Insurance Cards and Valid ID
2.) All Attached Documents-Completed
3.) Recent Medical Records
4.) Prescription Bottles
5.) Co-Payment

Please arrive 15 minutes before your appointment time.

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Patient Packet Completion Instructions

Thank you for taking the time to complete the enclosed **Patient Packet**. The information you provide will help us deliver the best possible care. Please follow the steps below to ensure all necessary details are included:

1. **Review and complete** each section of the Patient Packet thoroughly.
2. **Sign and date** all areas that are highlighted. This is crucial to avoid any delays in processing your paperwork.
3. **Medical Records Requirement:**
    - If you are currently taking any medication, we will need to obtain your medical records from the provider who prescribed that medication.
    - Our clinic will request your medical records directly from your **previous healthcare provider** once we receive your completed Patient Packet.
4. Once both your completed Patient Packet and medical records have been received, **our Scheduling Department will contact you** to set up your first appointment.

If you have any questions or need assistance with any part of the packet, please feel free to reach us at 530.708.8820 or info@modocmedicalcenter.org.

Packets completed electronically can be submitted via email to info@modocmedicalcenter.org. Please list "NEW PATIENT PACKET" in the subject line.

Thank you for your cooperation. We look forward to providing you with exceptional care.

Modoc Medical Center Clinic
1111 N Nagle Street, Alturas CA 96101
P: (530) 708-8820 F: (530) 233-4302

PATIENT REGISTRATION

Patient Information: (Please print clearly) Name must match what is on your insurance card or ID.

Last Name: _____ **First:** _____ **M:** _____

Sex/Gender Identity: ❑F ❑M ❑Male identifying as female ❑Female identifying as male ❑Other_____

Birthdate: _____ **SSN#**_____ **Marital Status:** ❑S ❑M ❑D ❑W ❑SEP

Mailing Address: _____ **City:** _____ **ST**:_____ **Zip**:_____

Physical Address (if different)**:** _____ **City**:_____ **ST**:_____ **Zip**:_____

Primary Phone: _____ **Work:** _____ **Cell**: _____

Message #: _____ **Email Address**: _____

Occupation: _____ **Retired?** ❑Yes ❑No **Date**: _____

Preferred Method of Contact: ❑Home Phone ❑Work ❑Cell ❑Message Phone ❑Text ❑Email **Okay to Text:** ❑Yes ❑No

Emergency Contact: _____ **Phone:** _____

Relationship: _____ **Does this person know that you are a patient at MMC Clinic?** ❑Yes ❑No

Parent or Guardian (if patient is minor) or Spouse Information:

Parent or Spouse Name: _____ **SSN#**_____

Address (if different than patient):_____ **City**:_____ **ST**:_____ **Zip**:_____

Phone (if different than patient): **Home**: _____ **Work**: _____

Cell: _____ **Birthdate**: _____ **Sex:** ❑F ❑M **Marital Status:** ❑S ❑M ❑D ❑W ❑SEP

Insurance Information:

Primary Insurance: _____

Subscriber Name: _____ **DOB**: _____ **Sex**:_____

Relationship to Patient: _____ **Subscriber ID**: _____ **Group**: _____

Secondary Insurance: _____

Subscriber Name: _____ **DOB**:_____ **Sex**:_____

Relationship to Patient: _____ **Subscriber ID**: _____ **Group**: _____

Financially Responsible Party: ❑Patent info above ❑Parent/Guardian/Spouse info above

Last Name: _____ **First Name**_____

Address: _____ **City**:_____ **ST**:_____ **Zip**:_____

Relationship to Patient: _____ **Phone**: _____

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Patient Last Name: _____ **First Name:** _____

Patient Demographics: To enable us to qualify for our grants and meet our Federal and State reporting requirements, along with possibly allowing us to offer more services, we ask for the following information. Your answers are strictly confidential. Your name will not be used. Please Circle or Check the appropriate box.

Language Spoken in your Home: ❑English ❑Spanish ❑Other: _____

Race (Check all that apply)**:** ❑White ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑Asian ❑Chinese ❑American Indian/Alaskan Native ❑Filipino ❑Japanese ❑Korean ❑Other ❑Declined

Ethnicity: ❑Hispanic/Latino ❑Non-Hispanic/Latino ❑Declined

Are you a Veteran?: ❑Yes ❑No **Agricultural (Farm) Worker?:** ❑Yes ❑No **If yes, are you:** ❑Seasonal ❑Migrant

Homeless?: ❑Yes ❑No **If yes, currently living in:** ❑Shelter ❑Transitional Housing ❑Doubled Up ❑Street ❑Other

Sexual Orientation (over 18 years old): ❑Heterosexual (Straight) ❑Gay or Lesbian ❑Bisexual ❑Choose not to disclose

Does the patient require a caregiver? ❑Yes ❑No If yes, Name of Caregiver: _____

Would you like information from your provider on Advanced Healthcare Directives? ❑Yes ❑No

Other health specialists Involved in patient's care:

Name	***City***	***Phone***
Name	***City***	***Phone***

Pharmacy Information:

What pharmacy do you use? _____ **Location**:_____

Sign and Authorize: The information I gave on this form is true and correct to the best of my knowledge.

_____ _____

Patient or Responsible Party Signature ***Date***

MEDICAL HISTORY

M/R#: _____
For office use only

Patient Name (Last, First) _____ **Date of Birth** _____

Please indicate **all** conditions you have previously experienced.

Heart Conditions
- ☐ Heart attack
- ☐ Heart failure
- ☐ Angina/heart pain
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Other

Neurological
- ☐ Epilepsy/siezures
- ☐ Migraine headaches
- ☐ Concussion
- ☐ Traumatic brain injury
- ☐ Memory issues
- ☐ Numbness in limbs
- ☐ Other

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Pleurisy
- ☐ Other

Skin and Allergy
- ☐ Eczema
- ☐ Hives/Hay Fever
- ☐ Skin rash
- ☐ Other

Kidney/Urinary
- ☐ Bladder infection
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Slow starting urine
- ☐ Other

Endocrine
- ☐ Goiter/Thyroid disease
- ☐ Diabetes
- ☐ Hormonal imbalance
- ☐ Other

Gastrointestional
- ☐ Stomach ulcers
- ☐ Colitis
- ☐ Bloody stools/vomit
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gallstones
- ☐ Other

Blood and Circulatory
- ☐ Anemia
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Other

Other
- ☐ Psychiatric (Depression, anxiety)
- ☐ Arthritis/bursitis
- ☐ Chronic back pain
- ☐ Cancer

Surgical History

Please list **all** surgeries and approximate dates.

_____

_____

_____

_____

Hospitalizations

Please list **all** hospitalizations and illnesses not covered above.

_____

_____

_____

1111 N. Nagle Street
Alturas, California 96101

MODOC MEDICAL CENTER
ALTURAS CLINIC

Phone: (530) 708-8820
Email: info@modocmedicalcenter.org

MEDICAL HISTORY

M/R#: _____
For office use only

Patient Name (Last, First) _____ **Date of Birth** _____

Medications
Please list **all current** medications (prescriptions and over-the-counter).

_____
_____
_____

Medication Allergies

_____
_____

Food Allergies

_____
_____

Family History
Please indicate if any immediate family members have experienced the following conditions.

Heart Conditions
- ☐ Heart attack
- ☐ Heart failure
- ☐ Angina/heart pain
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Other

Neurological
- ☐ Epilepsy/siezures
- ☐ Migraine headaches
- ☐ Concussion
- ☐ Traumatic brain injury
- ☐ Memory issues
- ☐ Numbness in limbs
- ☐ Other

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Pleurisy
- ☐ Other

Skin and Allergy
- ☐ Eczema
- ☐ Hives/Hay Fever
- ☐ Skin rash
- ☐ Other

Kidney/Urinary
- ☐ Bladder infection
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Slow starting urine
- ☐ Other

Endocrine
- ☐ Goiter/Thyroid disease
- ☐ Diabetes
- ☐ Hormonal imbalance
- ☐ Other

Gastrointestional
- ☐ Stomach ulcers
- ☐ Colitis
- ☐ Bloody stools/vomit
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gallstones
- ☐ Other

Blood and Circulatory
- ☐ Anemia
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Other

Other
- ☐ Psychiatric (Depression, anxiety)
- ☐ Arthritis/bursitis
- ☐ Chronic back pain
- ☐ Cancer

MEDICAL HISTORY

M/R#: _____
For office use only

Patient Name (Last, First) _____ **Date of Birth** _____

Women's Health History

Age of first period: _____ Date of last period: _____

Period Regularity
- ☐ Regular
- ☐ Irregular

Menstural Flow
- ☐ Light
- ☐ Normal
- ☐ Heavy

Menstrual Pain
- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Number of pregnancies: _____
Number of live births: _____
Number of C-section births: _____
Number of miscarriages: _____
Number of stillbirths: _____
Number of abortions: _____

Contraceptive Use
- ☐ Birth control pills
- ☐ IUD
- ☐ Condom
- ☐ Depo-Provera
- ☐ Implants
- ☐ Sterilization
- ☐ Other: _____

Gynecological Conditions
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Polycistic Ovary Syndrome (PCOS)
- ☐ Abnormal pap smear
- ☐ Menopausal symptoms (hot flashes, etc.)
- ☐ Hormonal imbalance
- ☐ Urinary incontinence
- ☐ Vaginal infection(s)
- ☐ Other: _____

Breast Health
- ☐ Regular self-exams
- ☐ Previous mammogram
- ☐ History of breast lumps
- ☐ Nipple discharge
- ☐ Other: _____

Gynecological surgeries

Please list all gynecological surgeries and/or procedures and approximate dates.

_____
_____
_____
_____

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AUTHORIZATION FOR TREATMENT

AUTHORIZATION FOR TREATMENT: The patient is under the care of their attending physician or the emergency room physician on duty and Modoc Medical Center (MMC) is not liable for any acts of omission in following the instructions of said physicians. The patient consents to an X-Ray examination, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered to the patient under the general and special instructions of the physicians. The patient recognizes that all medical doctors furnishing services, including emergency room doctors, radiologist, pathologists, and the like are independent contractors and are not employees or agents of MMC.

RELEASE OF INFORMATION: MMC may disclose all or any part of the patient's record to any person or corporation that is, is or may be liable under a contract or otherwise responsible to MMC, to the patient, or to a family member or employer of the patient, for all or part of MMC's charges. This includes, but is not limited to, MMC or medical services companies, insurance companies, worker compensation carriers, welfare funds or the patient's employer.

MEDICARE ASSIGNMENT OF BENEFITS: If applicable, the patient certifies that the information given by me in applying for payment under Title XVII (Medicare) of the Social Security Act is correct. The patient authorizes any holder of medical or other information to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or a related Medicare claim. The patient requests that payment of authorized benefits be made on my behalf to MMC.

FINANCIAL AGREEMENT: The patient agrees, whether they sign as an agent or a patient, that in consideration of the services rendered to the patient, they hereby individually obligate themselves to pay the account at MMC. The patient understands that if the charges are covered by insurance of any type, it is nevertheless my personal obligation to pay for all charges billed that are not covered by their insurance. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

HOSPITAL-WIDE CONSENT FOR HIV BLOOD TESTING: If health care personnel involved in the patient's care and treatment become exposed to certain bodily fluids, resulting in the possibility of transmission of blood borne disease, the patient's blood will be tested in order to detect whether or not the patient has antibodies to the Human Immunodeficiency Virus (HIV). This is the probable causative agent of Acquired Immune Deficiency (AIDS). The patient understands that this test is performed by with drawing blood and using a substance to test the blood. The patient also understands that there will be no charge for the performance of this test if occupational exposure occurs. If, during the course of treatment, the physician orders this test for diagnostic purposes, the patient will be charged accordingly.

The test and its accuracy and reliability are still uncertain, and the test results may, in some cases, indicate that a patient has antibodies to the virus when the patient does not (false Positive) or fail to detect that a patient has antibodies to the virus when the patient has antibodies (false Negative). A positive blood test result does not mean that the patient has AIDS and that in order to diagnose AIDS other means must be used in conjunction with the blood test. The patient may ask the responsible physician any questions regarding the nature of the blood test, its risks, and alternative testing before the test takes place.

The patient understands that the result of this blood test will only be made available to the Medical Records director and Infection Control Officer for employee follow up and to the patient's treating physician and will be kept strictly confidential.

By signing, I acknowledge that I have read the above "Authorization for Treatment." I also give consent for the performance of a blood test to detect antibodies to the HIV, without a physician's order as discussed above. I further understand that during my treatment, my physician may order an HIV test for diagnostic purposes, regardless of this consent.

PATIENT SIGNATURE _____

AUTHORIZED AGENT _____ **RELATIONSHIP**_____

WITNESS _____ **DATE**_____

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M/R#_____ Chief of Staff: Matthew Edmonds, MD

OFFICE PROCEDURES

1. Name: It is procedure to address you by first or last name. How would you like to be addressed?
   _____

2. Phone Confirmations: It is procedure to have you call 24-hours before your appointment to cancel.
   a. We may also call you regarding medical issues. List two phone numbers where you can be reached:
   Phone 1:_____
   Phone 2:_____
   b. If we cannot reach you at either number, may we call you at home? Yes / No
   c. If no one is home, may we leave a message on your answering machine? Yes / No

3. Verbal Authorization: It is procedure to get verbal authorization from all new patients to confirm appointments and leave messages if the patient is not available.

4. Sign-In Sheets: Insurance companies require that we have proof of your visit to our office for treatment on the date billed. In order to verify this, we have a daily sign-in sheet that you sign at the time of your appointment.

5. List those who we may share your medical information with: (Patient to initial all that apply)

Initial	Name	Phone Number
Initial	Name	Phone Number
Initial	Name	Phone Number

6. Our office is HIPAA-compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health Information and appreciate your help with this.

   PATIENT NAME_____

   SIGNATURE_____DATE_____

MODOC MEDICAL CENTER
A Public Entity
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Last Frontier Healthcare District

LAST FRONTIER HEALTHCARE DISTRICT
A Public Entity

M/R#_____

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 this carefully.

WHO WILL FOLLOW THIS NOTICE?

This notice describes our practices and that of:

- Any health care professional authorized to enter information into your medical record.
- All departments of the facility.
- Any volunteer we allow to help you while you are in the facility.
- All employees, staff, and other personnel.

All entities that are located on the facility campus will follow the terms of this notice. In addition, the entities on the facility campus may share medical information with each other for treatment, payment, or health care operation purposes described in this notice.

We Have a Legal Duty to Safeguard Your Protected Health Information (PHI)

We are legally required to protect the privacy of your health information. We call this information "Protected Health Information" or "PHI" for short. PHI includes information that can be used to identify you that we have created or received about your past, present, or future health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not disclose any more of your PHI than necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policy, we will promptly change this notice and post a new notice in the facility lobby. You can request a copy of this notice from the admissions clerk.

How We May Use and Disclose Your Protected Health Information

We use and disclose health information for many different reasons. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

- For Treatment. We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care. For example - if you are being treated for knee surgery, we may disclose your PHI to the physical therapy department to coordinate your care.
- To Obtain Payment for Treatment. We may use and disclose your PHI to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process our health care claims.
- For Health Care Operations. We may disclose your PHI to operate this hospital. For example, we may use your PHI to evaluate the quality of health care services that you received. We may also provide your PHI to our accountants, attorneys, consultants, and others to make sure we are complying with the laws that affect us.
- When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement - For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.

- 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 order from the court.
- 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 facility to funeral directors as necessary to carry out their duties.
- For Public Health Activities. For example, we report information about births, deaths, and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.
- For Health Oversight Activities. For example, we will provide PHI to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary:
    - For the institution to provide you with health care.
    - To protect your health and safety or the health and safety of others.
    - For the safety and security of the correctional institution.
- For Purpose of Organ Donation. We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
- For Research Purposes. In certain circumstances, we may provide PHI to conduct medical research. Before we use or disclose medical information for research the project will have been approved through a research approval process. We will ask for your permission if the research will have access to your name, address or other information that reveals who you are.
- To Avoid Harm. To avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- For specific Government Functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
- For Workers' Compensation Purposes. We may provide PHI or order to comply with workers' compensation laws.
- Appointment Reminders and Health-Related Benefits or Services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.
- Two Uses and Disclosures Require You to Have the Opportunity to Object
    - Patient Directories - We may include your name, location in this facility, and religious affiliation, in our patient director for use by visitors who ask for you by name, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
    - Disclosures to Family, Friends, or Others - We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your healthcare, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
    - Inquiries from Clergy - We may provide you name, locations in the facility, and religion to clergy members, unless you object in whole or part.

What Rights You Have Regarding Your PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI** - You have the right to ask that we limit how we use and disclose your PHI. We will consider your written request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You** - You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or be alternate means. We must agree to your written request as long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI** - In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it. We will respond to you within 5 working days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

D. **The Right to Get a List of the Disclosures We Have Made** - You have a right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures used for treatment, payment, health care operations, or authorization releases made by you. The list will also not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.
We will respond within 60 days of receiving your request. The list we will give you will include disclosures made after April 14, 2003, or for a period of no longer than six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year a reasonable fee may be requested once each calendar year.

E. **The Right to Correct or Update Your PHI** - If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reasons for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is:

   (i) Correct and complete,

   (ii) Not created by use,

   (iii) Not allowed to be disclosed, or

   (iv) Not part of your records.

F. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and or our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your bill, notify you that the change was made, and notify others that need to know about the change in your PHI.

How to Express a Concern About Our Privacy Practices

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the Privacy Officer who can be contacted at the following address or phone number:
Risk Management PO Box 190

1111 N. Nagle Street Alturas, CA 96101
(530) 708-8888

You also may send a written complaint to the Office for Civil Rights, U.S. Department of Health and Human Services, 50 United Nations Plaza - Room 322, San Francisco, CA 94103. We will take no retaliatory action against you if you file a complaint about our privacy practices.

Person to Contact for Information about This Notice or to Complain About our Privacy Practices

It is the policy of Modoc Medical Center to provide quality services to all of our customers. To improve patient safety and quality of care we welcome all comments. If you have complaints or concerns about patient safety or quality of care you, please contact our Risk Manager at the same phone number and address as listed above for our Privacy Officer. We will make every effort to assist you. If you do not believe your issue has been resolved, you are encouraged to contact hospital administration. You are also encouraged to contact the State of California Department of Public Health (CDPH) at (800) 554-0350, to report concerns.

Other Uses of Medical Information

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

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice at any time. You may obtain a copy of this notice from the Admitting Department or after hours the Nursing Department.

Modoc Medical Center Clinic
1111 N Nagle Street, Alturas CA 96101
P: (530) 708-8820 F: (530) 233-4302

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

M/R#_____

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information. You have a legal right to review our "Notice of Privacy Practices." Before you sign this consent, we encourage you to read it in full. If you have any questions regarding the "Notice of Privacy Practices," you are encouraged to contact the Privacy Officer and they will assist you.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice from our Admissions Clerk.

_____

Patient Signature (Name if Unable to Sign) **Date**

_____

Parent/Conservator/Guardian (Relationship to the patient if signed by someone other than patient) **Date**

If the Patient (Parent/Conservator/Guardian) is unable to sign, explain the reason, and two staff members must sign and date.

Explanation: _____

_____

_____

Staff Member **Date**

_____

Staff Member **Date**

M/R#_____

Appointment Cancellation, Missed Appointment, and Late Arrival

The vision of Modoc Medical Center's (MMC) Family Practice Clinics (Clinics) is to provide the highest quality healthcare in a way that reflects kindness and respect while allowing all people to feel valued as human beings. To ensure that each patient is given the proper amount of time for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time.

As a courtesy, an appointment reminder is attempted one (1) business day prior to your scheduled appointment. If you do not receive a reminder call/message or the number has been disconnected or changed this policy remains in effect. It is the patient's responsibility to keep contact information current with our office and to arrive for their appointments on the scheduled date and time.

We understand that appointments are missed due to emergency situations. Please call the Clinic promptly if you are unable to show up at your scheduled time. If you need to reschedule your appointment, we request that you give our office at least 24 hours' notice. If you do not provide us with at least 24-hours' notice, or if you do not show up for a scheduled appointment, this will be considered a Missed Appointment.

Our appointment Cancellation, Missed Appointment, and Late Arrival Policy states:

- **Three (3) no-shows in a six (6) month period or four (4) in a 12-month period may lead to you being dismissed from Alturas Family Practice Clinic and Canby Family Practice Clinic.**
- **First Missed Appointment:** Patient will be contacted by our staff and offered to reschedule the missed appointment.
- **Second Missed Appointment:** Patient will receive a phone call and be mailed a letter reinforcing the Missed Appointment Policy as well as indicating potential of dismissal from the Clinic should they fail to keep future appointments or provide appropriate notification.
- **Third Missed Appointment:** If within six months, the Clinic Provider and Clinic Director/Manager will review the Patients records to determine if dismissal from care is appropriate. If dismissal is appropriate, a Certified Letter will be mailed via USPS to the patient with instructions to seek medical care elsewhere, the Patient will also receive a second copy of the letter sent via regular mail. The patient will be given 30 days of medications, if needed, to allow time for care to be established.
- **Fourth Missed Appointment:** If within 12 months, Clinic Director/Manager and Medical Provider will review the Patient's record/chart to determine appropriateness of dismissal. If dismissal is deemed appropriate, a letter will be sent via Certified Mail/Return Receipt Required to the patient as well as a second copy of the letter sent via regular mail.
- **Late Arrival:** Any patient more than five (5) minutes late for any 15-minute or same-day appointment, or seven (7) minutes late for a 30-minute or longer appointment will be asked to reschedule. The front desk staff will notify the Medical Provider of the tardy patient and the Medical Provider will make the decision as to whether they can see the patient or not.

***If a patient is discharged from the Clinic(s) and has a medical emergency, please visit the Emergency Department at MMC.**

I have read and understand MMC's Family Practice Clinics Appointment Cancellation, Missed Appointment, and Late Arrival Policy and I understand that I will be held accountable by its terms. I also understand that such terms may be modified depending on the best interest of the patients, employees, and organization.

Patient Signature _____ **Date** _____

***If declining to sign, please understand that the terms contained in these policies are still in effect and will be enforced for all scheduled appointments.**

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

AUGMEDIX Technology

Your providers are using a new technology called AUGMEDIX. AUGMEDIX is a technology that uses a remote assistant/scribe to assist your provider with documenting your visit today. This assistant/scribe will assist in creating your electronic medical record in real time.

I have read the frequently asked questions sheet given to me by the **Medical Clinic at Modoc Medical Center** and have had all my questions answered by the health center staff.

I have also been informed that it is my choice whether or not I want AUGMEDIX utilized during my visit with my provider.

By signing below, I am consenting to the use of AUGMEDIX technology. This consent is valid from the date I sign, for all future visits. At any point in time it is my right to decline the use of AUGMEDIX

Patient Name _____ Date of Birth _____

Patient Signature _____

Date _____

Front Office Staff _____

*****REQUEST FOR RECORDS*****

We will need to obtain your primary care records prior to scheduling an establishing appointment. We would also like to have your specialty records to aid you in your care. The following three pages will need to be completed in full and signed appropriately. We will fax or mail the requests as appropriate.

INSTRUCTIONS:

1.) **Primary Care** *Authorization for Release of Protected Health Information*

2.) If applicable: **Specialist** *Authorization for Release of Protected Health Information*

Please feel free to make a copy of the Specialist page should you have more than one Specialist for which we will need to obtain your records.

MAKE SURE TO COMPLETE **IN FULL** THE FOLLOWING:

THE PATIENT INFORMATION SECTION

THE FACILITY NAME SECTION

DOCUMENTS TO BE DISCLOSED/RELEASED SECTION

3.) The last page with your signature, printed name, and date. If other than the Patient is signing, you must attach the legal document that gives permission to sign on behalf of the Patient.

Please Note: Failure to complete the Authorizations in full, may cause a delay in your care. Authorizations for Records are governed by HIPAA laws. If not completed in full and properly your previous care providers may reject the request for records.

PRIOR PRIMARY CARE

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I understand that information disclosed pursuant to this authorization could be redisclosed by the recipient and that such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal law (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Please be sure to provide all information requested, failure to do so may invalidate this authorization.

PATIENT INFORMATION:

Patient Name:		Last 4 of SS#:
Address:	City:	State:
Zip Code:	Telephone:	Date of Birth:

I HEREBY REQUEST AND AUTHORIZE:

Name: **MODOC MEDICAL CLINIC**

Address: P.O. BOX 190, 1111 N NAGLE ST	City: ALTURAS	State: CA	Zip Code: 96101
Telephone: 530-708-8820	Fax: **530-233-4302**		

CHECK ONE BOX: ☐ To **release** to ☒ To **request** from

Name:

Address:	City:	State:	Zip Code:
Telephone:	Fax:		

In the following manner:

- ☒ Copies by mail (or)
- ☒ Copies by **fax**
- ☐ Copies to be picked-up
- ☐ Other_____

For the following purpose(s):

- ☒ Continuity of care/Treatment
- ☐ Legal/Attorney
- ☐ Personal/Patient Request
- ☐ Insurance
- ☒ **Transfer Of Care**
- ☐ Other_____

Documents to be disclosed/released:

Initial as appropriate

- ☐ Alcohol/Drug Treatment
- ☐ STD, HIV & AIDS
- ☐ Sexual Assault
- ☐ Child/Elder Abuse/Neglect
- ☐ Mental Health
- ☐ Reproductive Health

- ☐ **Hospital Records**
- ☐ **Clinic Records**

Type of Records being released/requested:

_____

_____

_____

DOS: _____

SPECIALIST/HOSPITAL

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Completion of this document authorizes the disclosure and/or use of health information about you. Please be sure to provide all information requested, failure to do so may invalidate this authorization.

PATIENT INFORMATION:

Patient Name:		Last 4 of SS#:
Address:	City:	State:
Zip Code:	Telephone:	Date of Birth:

I HEREBY REQUEST AND AUTHORIZE:

Name: **MODOC MEDICAL CLINIC**

Address: P.O. BOX 190, 1111 N NAGLE ST	City: ALTURAS	State: CA	Zip Code: 96101
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CHECK ONE BOX: ☐ To **release** to ☒ To **request** from

Name:			
Address:	City:	State:	Zip Code:
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- ____ Child/Elder Abuse/Neglect
- ____ Mental Health
- ____ Reproductive Health

- ☐ **Hospital Records**
- ☐ **Clinic Records**

Type of Records being released/requested:

_____

_____

_____

DOS: _____

This authorization will expire on:

☐ **Twelve months from date signed** **or** ☐ **Other**_____

My authorization is given freely with the understanding that:

- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- I have the right to receive a copy of this authorization.
- It is my right to be free from retaliation or other penalty for failing to sign the authorization.
- This authorization is valid for a 12-month period from the date it is signed, unless otherwise specified above.
- A photocopy or fax of this authorization is as valid as the original.
- Modoc Medical Center, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Substance Abuse Records are covered by 42 CFR Part 2, Which prohibits further disclosure of the information for which this release has authorized.
- Provider must release records within 15 business days of receiving a valid written request.
- I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law.
- I attest that the use of disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii).

_____ _____

Signature of Patient or Authorized individual Date

_____

Print Name

_____

If signed other than patient, please indicate relationship

(Verification of identity and/or authority to act on patient's behalf will be required.)