LaPine Community
HEALTH
CENTER

Welcome to La Pine Community Health Center (LCHC). Thank you for choosing us to be your health care provider. LCHC is a primary care health center where a person can come to receive medical care. Our health care providers, such as doctors, nurse practitioners, physician assistants, behavioral health team, clinical pharmacist, registered dietitian, and outreach team are here to help with your health needs. They can decide what to do for you by providing examinations, X-rays, and laboratory testing. Our providers treat people for ongoing illnesses such as high blood pressure, diabetes, COPD, high cholesterol, and others. They also treat patients for minor issues such as sore throats, minor cuts, urinary tract infections, and other things.

Your provider will ask you questions about your health. You may be asked about medical treatment you have had before coming here. They may also do a physical examination and perform others test such as labs or x-ray. This information is used to help decide how to treat you.

Your provider may prescribe medicine for a short time or longer if needed. If it is necessary, you may be asked to come back to have more tests. Your provider needs to be sure the medicine is doing what it needs to do. Your provider may suggest things that you can do to be healthier. If you need to see a specialist, then your provider will help set that up for you. **No controlled substances will be prescribed during your first visit.**

We provide:

- Annual Exams to help make sure your health is good and to catch diseases before they get worse
- Disease Management (such as Diabetes, high blood pressure, COPD and others)
- Women's Health (Pap tests, breast exams)
- Men's Health Exams
- Well Child Exams (baby check-ups)
- Children's Health (annual wellness visits)
- Sports and School Physicals (completed during annual wellness visits)
- Immunizations (shots to prevent diseases)
- Developmental Screening (to be sure your child is developing as they should)
- Pre-employment drug testing (done by Interpath Lab here in our health center)
- Minor Procedures (mole removals, minor lacerations/cuts, etc.)
- Splinting
- Internal Medicine
- Occupational Medicine
- Preventative Services
- Behavioral/Mental Health
- Family Medicine
- Digital X-ray services
- Laboratory services (blood testing, urine testing and others) done by Interpath lab in our health center)
- Help applying for medication programs for reduced cost medication if you qualify
- Help applying for Oregon Health Plan (Medicaid)
- Help applying for other community services you may need and qualify for
- Outreach services
- Clinical pharmacist services
- Nutrition counselling

Our health center wants everyone to receive the medical services they need. If you cannot pay for seeing a provider, we may be able to help you. If you have insurance that does not pay enough to help you get the treatment you need, we may have a way to help you. You will be asked to fill out some forms and you will need to show us proof of all money that comes into your household.

If you do not have health insurance, you will be asked to apply for Oregon Medicaid. If you do not have health insurance, you may be able to be treated for a lower price. This price is decided by the amount of money your household receives. This fee may be as low as $25.00, $30.00, $35.00 or $40.00 for each visit, depending on your household's income. If additional medical things performed in our office are needed, it may cost more. We offer a 25% discount for paying your bill in full the day you see your provider if not using our discounted fee schedule and if the services are medically necessary.

If you are approved for our reduced rate, you will be given a card that can be used for a discount on your medications at Drug Mart, the pharmacy here in the building. If your medication is on their list of available medications, you may get it for a lower cost.

If you have any questions about our services please ask for help.

Patient Consents and Notice of Privacy Practices

Patient Name (please print): _____ DOB: _____ Date: _____

Consent to Treatment

By signing below, I agree to receive medical care from La Pine Community Health Center (LCHC).
I understand that:

- This consent to treatment will be in effect as long as I am seen at LCHC.
- I may cancel this consent in writing at any time.

Consent to Disclosure of Protected Health Information

My protected health information is made up of my health history, testing and treatments.
By signing this form, I understand and agree that LCHC may use or release my protected health information for purposes of:

- Providing treatment;
- Payment;
- Healthcare operations;
- As is reasonably necessary to comply with any court order, subpoena, or any other legal requirements(s) or regulation(s) as long as a separate authorization is not required under HIPAA regulations; or
- As is otherwise permitted under HIPAA regulations.

Notice of Privacy Practices and Patient Rights

LCHC's Notice of Privacy Practices gives information about how LCHC may use and release protected health information about you.
I understand that:

- I have the right to receive a copy of La Pine Community Health Center's Notice of Privacy Practices.
- I may request a copy at any time.
- The notice may be revised.
- I am entitled to a copy of any revised Notice of Privacy Practices.

By signing below, I acknowledge the above and that I have received or have been offered a paper copy of LCHC's Notice of Privacy Practices.

Patient-Centered Primary Care Home

By signing below, I acknowledge that I understand that LCHC is recognized as a Patient-Centered Primary Care Home (PCPCH), certified through the Oregon Health Authority. As a PCPCH, LCHC will better coordinate my care so that I can access the services that I need, listen to my concerns, offer after-hours access and help me play a bigger role in my own health. I agree to communicate my health concerns in a clear manner to my provider team, and follow my care plan to the best of my ability.

Emergency Medical Transports From La Pine Community Health Center

If your medical provider recommends emergency medical transport by ambulance from one of our health center locations to the St. Charles Health Systems emergency department, you have the right to refuse the transport against medical advice. If you choose to be transported according to your medical providers recommendation, your insurance will be billed by the ambulance service provider. If you do not have insurance, the invoice will be billed to you.

I understand that I have the right to refuse emergency medical transport and that I will be asked to sign an AMA (Against Medical Advice) from.

I understand that if I choose to be transported, my insurance (or I) will be billed for the transport.

I hereby acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

_____ _____

Patient or Responsible Party Signature Date

_____

Printed Name of Signer

La Pine Community HEALTH CENTER

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Pediatric Disclosure of Protected Health Information (PHI)
(HIPAA Form)

Patient Name (please print): _____ DOB: _____ Date: _____

La Pine Community Health Center may: (*check all that apply*)			
*Leave **medical** information on voicemail:*	□ Cell Phone	□ Home Phone	□ None
*Leave **billing** information on voicemail:*	□ Cell Phone	□ Home Phone	□ None
Use for automated appointment reminders or general messages:	□ Cell Phone	□ Home Phone	□ None

If there is anyone that you would like to give us permission to speak with regarding your healthcare, please indicate below:

I authorize La Pine Community Health Center to speak to the following people, in person or by telephone:

1. Name:_____ Relationship:_____ Phone: _____

Regarding: □ Schedule or cancel appointments □ **All** information
□ Other: (please specify) _____

2. Name:_____ Relationship:_____ Phone: _____

Regarding: □ Schedule or cancel appointments □ **All** information
□ Other: (please specify) _____

List legal representative, guardian, power of attorney, etc., if any: (*must provide proof)*

1. Name:_____ Relationship:_____ Phone: _____

2. Name:_____ Relationship:_____ Phone: _____

If the patient is a minor, please give us the names of both parents:

Mother's Legal Name:_____ Father's Legal Name: _____

List anyone other than parents or legal guardian who may seek medical care for the minor patient: (*stepparents, grandparents, etc.)*

1. Name:_____ Relationship:_____ Phone: _____

2. Name:_____ Relationship:_____ Phone: _____

3. Name:_____ Relationship:_____ Phone: _____

Are there any additional accommodations needed?

Please specify: _____

_____

This authorization may be changed or revoked in writing at any time. It will remain in effect until that time or until the minor patient turns 18 years of age.

Patient or Parent/Guardian Signature: _____ Relationship: _____
(If under 15 years of age, parent or legal guardian must sign)

Printed Name of Signer: _____ Date: _____
(If parent or legal guardian)

Pediatric Medical History

Patient Name (please print):_____ **DOB**:_____ **Date**:_____

Family Information	
Mother's Name:	□ Biological □ Step □ Adoptive □ Foster Lives with child □ Y □ N
Father's Name:	□ Biological □ Step □ Adoptive □ Foster Lives with child □ Y □ N
Siblings (at home, first names & ages):	
Other (name & relationships:	
Are there any tobacco users/smokers in the home? □ Y □ N	Is anyone in the home a regular user of alcohol/drugs? □ Y □ N
Are there any guns/firearms in the home? □ Y □ N	Is anyone in the home being hit/hurt or touched in a bad way? □ Y □ N

Birth History	
Pregnancy was: □ Full Term (>37 weeks) □ Early □ Late	Pregnancy lasted:_____weeks *(normal is 40)*
Birth Weight:_____pounds_____ounces	
Pregnancy Complications:	
Tobacco/Alcohol Use While Pregnant? □ Tobacco □ Alcohol	
Birth Complications:	
Hospital Stay Lasted: □ 1-3 days & routine	□ Prolonged >3 days due to:
Hearing Screen Passed: □ Y □ N	

Surgeries/Hospitalizations

Year	Reason for Surgery/Hospitalization

Chronic Illnesses or Developmental Problems/Delays

Family Health History (grandparents, parents, siblings, and children) Adopted? □

Problem	Relationship	Age	Type
Arthritis			
Cancer			
Depression			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Stroke			
Other			

Immunizations

Do you believe you/your child is up-to-date on recommended immunizations? □ Yes □ Not Sure

Do you have an up-to-date copy of yours/your child's immunization record? □ Yes □ Not Sure

Allergies (please list; include medications, foods, etc)

Current Medications (prescription, over the counter, herbal, inhalers)

Provider Signature:_____ Date:_____

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How did you hear about our health center?
□ TV □ Newspaper □ Magazine □ Another doctor □ Friend/Family □ Internet □ Billboard □ Radio □ Other: _____

Patient Information

Last Name	First Name	M.I.	Today's Date	DOB (mm/dd/yyyy)

Social Security Number	Sex at Birth	What gender do you identify as?
	□ Male □ Female	□ Male □ Female □ Trans – Male to Female □ Trans – Female to Male □ Other

Sexual Orientation	Preferred Pronoun
□ Straight □ Bisexual □ Choose not to disclose □ Lesbian/Gay □ Unsure □ Other _____	□ he/him □ she/her □ they/them □ ze/zim □ Choose not to disclose

Street Address			Home Phone Number	Mobile Phone Number
City	**State**	**Zip**	**Primary Language**	
Mailing Address □ *Same as above*			**Email Address**	
City	**State**	**Zip**	**Marital Status** □ Single □ Divorced □ Widowed □ Domestic Partnership □ Married – Spouses Name _____	

Employment Information

Employment Status (check one) □ Full time □ Part time □ Unemployed □ Retired □ Self-employed □ Student – f/t □ Student – p/t			
Employer			**Employer Phone Number**
Employer Address	**City**	**State**	**Zip**

Emergency Contact Information

1st Emergency Contact	Relationship to Patient	Phone Number
2nd Emergency Contact	**Relationship to Patient**	**Phone Number**

Responsible Party Information

Responsible Party's Name			DOB (mm/dd/yyyy)	Social Security Number
Street Address			**Primary Phone Number**	**Secondary Phone Number**
City	**State**	**Zip**	**Relationship to Patient**	**Sex** □ Male □ Female

Primary Insurance

Insurance Company		Coverage Start Date
Policyholder's Name	**DOB (mm/dd/yyyy)**	**SSN**
Employer	**ID #**	**Group #**

Secondary Insurance

Insurance Company		Coverage Start Date
Policyholder's Name	**DOB (mm/dd/yyyy)**	**SSN**
Employer	**ID #**	**Group #**

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Patient Communication Preference Form

Please answer the questions below to help us communicate better with you.

Patient Name (please print): _____ DOB: _____ Date: _____

How would you like us to communicate with you on the following? Please circle which option(s) works best for you.

Appointment reminders	Phone call	Text	
Billing	Phone call	Mail	MyChart
Medical	Phone call	Mail	MyChart

If you would like to sign up for MyChart, our online patient portal, to send messages to your provider, request appointments, receive communication from us, pay your bill and review your test results, initial here_____.

I would like the MyChart activation code sent to me by text (cell #)_____or email _____

What is your preferred language? Spoken_____ Written _____

Do you need an interpreter? Please circle which best applies. Yes/No If yes, which language is needed? _____

Please circle the option below which best describes your English Fluency.

Excellent Very good Good Not good

Patient Assistance: Please circle all that apply to you.

Visually impaired – If yes, at what age did this begin?_____Hearing impaired – If yes, at what age did this begin? _____

Is this a disability? Yes No

By signing below, I acknowledge that I understand that La Pine Community Health Center may occasionally communicate with me via the email address provided on the Patient Information form for quality improvement efforts, appointment reminders and general information. I understand that no medical information or test results will be communicated via email. I understand that I have the right to refuse email communications by requesting that my email address be removed from my file.

Patient or Parent/Guardian Signature: _____ Relationship: _____
(If under 15 years of age, parent or legal guardian must sign)

Printed Name of Signer: _____ Date: _____
(If parent or legal guardian)

Financial Policy and Agreement

Patient Name (please print): _____ DOB: _____ Date: _____

Patient Responsibility

Payment is required at the time services are rendered **unless other arrangements have been made in advance**. This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. As a thank you for paying your balance IN FULL, we offer a 25% discount off the balance due. We cannot take the discount off co-pays, sliding fee scale visits or elective services. La Pine Community Health Center accepts cash, personal checks, debit and credit cards. A service charge may be added for returned checks.

Past Due Accounts

Patients with an outstanding balance must make arrangements for payment. We realize that people may have financial difficulties at times. Therefore, we have implemented a payment plan for those who cannot pay in full at the time of service.
On accounts where a payment arrangement has been made, payment is due by the date agreed upon. Patient balances greater than 90 days old or those failing to honor agreed upon payment terms may be turned over to our collection agency. Please contact us to apply for our Discounted Fee Program or for assistance with applying for Oregon Health Plan (OHP).

Cancellations/Missed Appointments

If you are unable to keep your appointment, please call us as soon as possible; appointments cancelled less than 24 hours in advance are considered a NO SHOW. We realize emergencies come up and your plans may change. Giving us as much notice as possible (at least 24 hours) helps us to better serve you and our other patients. If you fail to keep your appointments with us for a total of three times, you may be discharged from our practice.

Insurance

After we provide healthcare services to you, we will bill your insurance for you. We will bill all insurance companies, but we have no control over the dollar amount a non-participating company will pay for your services. Payment has been set by these companies without our input and as a result, you could possibly be left with an account balance higher than expected. You, the patient, have a contract with your insurance company and we cannot guarantee that your insurance will cover our services. We suggest that you verify coverage with your insurance company prior to your appointment. Payment for services provided to you is ultimately your responsibility.

It is the patient's responsibility to notify the health center of any insurance coverage changes. Please bring your insurance card to every visit so that we may ensure that our records are kept current.

Discounted Fee Program (Sliding Fee Scale)

La Pine Community Health Center (LCHC) is proud to offer a Discounted Fee Program (sliding fee scale) to all qualifying patients. Upon approval, your visit may be discounted to a nominal fee. To apply, please request an application from an employee, complete the application and return with proof of income for *every* person in your household.

Assistance or Questions

If you need assistance or have questions regarding billing issues or the Financial Policy, please contact the billing office between: 8:00 a.m. and 5:00 p.m. Monday through Friday at 541-536-3435.

I have read and understand La Pine Community Health Center's Financial Policy. I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the agency for costs of collections, including attorney fees. I accept full financial responsibility and hereby assign to La Pine Community Health Center any and all insurance benefits due to me to the full extent of my financial obligation to said provider. I understand that I am responsible to the provider(s) for charges not covered by this assignment. I agree that payments will not be delayed or withheld because of any insurance coverage and all proceeds of insurance are assigned and/or payable to this office where applicable. In the event of non-payment I will bear the cost of collection and/or court costs and reasonable legal fees, should this be required.

I hereby authorize the release of pertinent medical records to my insurance carrier(s).
I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

_____ _____

Patient or Responsible Party Signature Date

_____

Printed Name of Signer

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Information Requested for our Federal Funding

Patient Name (please print):_____ DOB:_____ Date: _____

Please tell us about yourself or, if you are accompanying a patient, the patient who is being seen today. As a Federally Qualified Health Center (FQHC) we are required to report the information requested on this survey. Your cooperation is greatly appreciated and your answers will be held in the strictest confidence.

Housing	
Has your housing situation changed dramatically in the past year?	□ Yes □ No
Are you living in a shelter or other transient housing?	□ Yes □ No

Household Information	
How many people live in your household?	
Estimated yearly household income	$

Veteran Status	
Are you a United States Veteran?	□ Yes □ No

Ethnicity, Race & Agricultural Work Status	
Are you Hispanic or Latino?	□ Yes □ No
Race: (check all that apply)	□ White □ African American □ Asian □ Native American □ Alaskan Native □ Native Hawaiian □ Pacific Islander □ Other
In the past 24 months, have you or another wage earner in your immediate family • Been hired to do farm work including the processing, preparation or delivery of agricultural products? □ Yes □ No • Earned over ½ of your family income from farm work? □ Yes □ No	
In the past 24 months have you • Moved from this area to another country or state in search of farm work? □ Yes □ No • Lived in this area and only worked during the harvest season? □ Yes □ No	

LaPine Community HEALTH CENTER

Professional Disclosure Statement-Behavioral Health Consultants

La Pine Community Health Center
51600 Huntington Rd
PO Box 3300
La Pine OR 97739

Behavioral Health Consulting is a model of health care that focuses on increasing positive health outcomes of those we serve. Your provider may ask you to see a Behavioral Health Consultant (BHC) during your visit. Your provider will continue to take care of your medical needs and may work with you and the BHC on some of the following situations that could be causing challenges in your life:

- Difficulty with life situations
- Stress
- Family troubles
- Coping with medical diagnosis
- Substance use
- Child behaviors
- Eating and activity changes for healthy weight
- Learning/memory
- All types of mental health issues
- Sleep
- And more

Services from the BHC's does not include:

- Court ordered evaluations or care
- Special evaluations (e.g., custody or psychological)
- Long-term therapy

La Pine Community Health Center has Behavioral Health Consultants who respond to requests for consultations.

Beth Erickson, LCSW is a Licensed Clinical Social Worker. Beth is a long time resident of La Pine and loves living and working in our rural community. Beth's social work experiences range from case management to direct clinical Behavioral Health services for patients of all ages.

Philosophy and Approach: Beth's practice utilizes Strengths and Empowerment theories, Family Systems Theory and Positive Psychology. She is interested in seeking out and assisting in recognizing individual strengths and focusing on the possibilities rather than the impossibilities of personal change. Beth recognizes the value in exploring systems that prevent as well as support individual growth and is passionate about integrating the culture of Trauma Informed Care into all areas of wellness. Services provided follow the National Association of Social Workers Code of Ethics.

Kaely Haskins, LCSW is a Licensed Clinical Social Worker for the State of Oregon. Kaely lives in the Eugene Oregon area providing telehealth services to the La Pine Community Health Center clinics and is passionate about community mental health. As a part of Kaely's LCSW status, she completes continuing education each year and additional training to further her educational goals. Kaely has social service experience ranging from direct therapy to case management for all ages.

Client Bill of Rights

As a patient receiving services from an Oregon licensee or Registered Counselor Intern in the state of Oregon you have the following rights: (Code of Ethics (OAR 833-060-0001 (4) (h))

- To expect that a licensee has met the minimum qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
- To obtain a copy of the Code of Ethics;
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;
- To be assured of privacy and confidentiality while receiving services as defined by rule or law, including the following **exceptions:**
  a) Reporting suspected child abuse;
  b) Reporting imminent danger to the patient or others;
  c) Reporting information required in court proceedings or by client's insurance company or other relevant agencies;
  d) Providing information concerning licensee case consultation or supervision; and
  e) Defending claims brought by the client against licensee;
- To be free from being the object of discrimination on any basis listed in subsection (9) of this rule while receiving services.

- **Fee schedule**- This practice serves all patients regardless of ability to pay. You may be billed for BHC services depending on your insurance plan.

Patient Name:_____ Date of Birth:_____

Signature:_____Today's Date:_____