

The logo features a stylized sun with rays on the left. To its right, the text 'EDC' is positioned above 'Community Health Center' in a large, black, handwritten-style font. Below this, '& Placerville Health and Wellness Center' is written in a smaller, blue, sans-serif font.

EDC
Community Health Center
& Placerville Health and Wellness Center

4327 Golden Center Drive, Placerville 4641 Missouri Flat Road Placerville (530) 621-7700

elcome to El Dorado County Community Health Center:

Please arrive on the day and time listed on the attached appointment card. If you are not able to keep this appointment you must call at least 24 hours in advance to reschedule or cancel, by doing this will allow us to accommodate other patients needing medical care.

Enclosed are the following forms: **Health Questionnaire, Patient Information Sheet and a Privacy Consent**. Please complete all the enclosed forms and *bring them to your appointment*. Some of the other important things you must bring to your appointment are:

- Current medications and/or vitamins you may be taking
- Current insurance coverage cards
- Previous medical records or their names, addresses and phone numbers

We participate in most major medical insurance plans and will file a claim to them as a courtesy. It will be necessary for you to bring your insurance card each time you visit this office. Co-pays and deductibles will be collected at the time of service. We will accommodate you by accepting payment in the form of cash, check, Visa or MasterCard. ***We do not participate in Workman's Compensation cases or bill any type of Motor Vehicle Accident Insurance.***

Minors must have a signed consent form on file from a parent or legal guardian to be treated at the Community Health Center.

If you have questions, please call us at 530-621-7700. A representative will answer calls during work hours between 8:00 am until 5pm.

We are glad you have chosen El Dorado County Community Health Center as your Primary Care Providers and we look forward to providing you with the best healthcare.

Sincerely,

The Staff and Providers at El Dorado County Community Health Center



Information for Patients:

Health Center Policy Regarding Prescription Refills for all Types of Medications.

- Due to the very high number of medication refills that we process every day, we require request be submitted three (3) business days prior to need for all refills, and **it may take three business days to process your request.**
- Please call you pharmacy and have them FAX us a refill request. Please do not call us directly unless you need a hand written prescriptions for a controlled medication that requires a specific written prescription each time.
- If you need written prescriptions for a mail-order pharmacy, please call the Health Center with your request. Specify if you want the prescriptions mailed to your home or if you will pick them up. **Please allow three business days for these to be written.**
- We do not process refill requests on holidays or weekends or after 5pm.
- We do not refill antibiotics without follow-up visit.

Please do not call the office multiple times to check on the status of your medication refill. Our providers review these request during the day in between seeing patients. They do their best to process hundreds of refills every week as fast as they can for your convenience. Multiple phone calls slow down then process for everyone and if excessive, can be viewed as harassing and may be grounds for dismissing you as a patient of the Community Health Center.

Thank you



EDC
Community Health Center
Placerville Health and Wellness

4327 Golden Center Drive, Placerville CA • 4641 Missouri Flat Road, Placerville CA • Tel (530) 621-7700 Fax (530) 621-7707

Re: New Medication Prescriptions

To: Our New and Existing Patients

We feel privileged that you have chosen us as your new medical providers and we hope to provide for you years of quality Primary Medical Care. We are fortunate that we have many years of experience amongst our high quality Health Care providers, who include Family Medicine Doctors, Family Nurse Practitioners, Physician Assistants, and Psychologists.

Our Patients come to us after seeing many great medical providers in our community and beyond. Occasionally, we are asked by our patients to continue a medical treatment regimen that was started by these qualified medical providers. Sometimes we find that it is important to change a medication regimen based on our findings and the most current medical knowledge of the day. Examples of typical medication issues that come up are for blood pressure, diabetes, pain, and anxiety medications.

It may be that today, on your first day, we may not feel comfortable continuing a course of medication that your previous doctors have started. The reasons will be explained to you by your medical provider and will be based on the best current medical knowledge. Though our choices may or may not match what has been done in the past for you, we always have your best health in mind.

Thank you for your respect and understanding. We strive to practice the best medicine and will work with you to achieve your best health.

Respectfully,

The Medical Director and Provider Staff.



Please assist us by filling out this worksheet about your medical and personal history so we can get to know you better.

Today's Date: _____

Your Name _____ Date of Birth _____ Current Age _____

1. Your current or previous Primary Physician: Name:	Address	Phone #
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2. Specialists you see	For what problem?	Address:	Phone:
_____	_____	_____	_____
_____	_____	_____	_____

3. Medication Allergies:	Type of reaction:
_____	_____
_____	_____
_____	_____

**** Please bring all your medicines (including vitamins and herbal supplements) with you to the office for review.**

4. Medicines you take:	Dose	How many times a day?	Prescribing Doctor

5. Medical problems you are being treated for:	Year of onset	Surgeries you have had:	Date

6. Health Care Prevention tests	Year	Normal	Abnormal	7. Tobacco use: <input type="checkbox"/> Never used tobacco (smoke or chew)
Mammogram, Breast exam		N	Abn	<input type="checkbox"/> Cigarettes # packs/ day # of years
Pap Smear		N	Abn	<input type="checkbox"/> Chew tobacco
Colonoscopy or Sigmoidoscopy		N	Abn	<input type="checkbox"/> I Quit ! When:
Fecal occult blood cards		N	Abn	<input type="checkbox"/> I want to quit
Prostate exam		N	Abn	
PSA		N	Abn	8. Alcohol use: <input type="checkbox"/> None

Cholesterol test		N	Abn	Types: <input type="checkbox"/> Wine, <input type="checkbox"/> Beer, <input type="checkbox"/> Hard liquor
Blood Glucose		N	Abn	# drinks: per <input type="checkbox"/> Day, <input type="checkbox"/> Week, <input type="checkbox"/> Month
Other:		N	Abn	
		N	Abn	9. Other Recreational Drugs used: <input type="checkbox"/> Never used
		N	Abn	Types:

10. Married Single Divorced Widowed Domestic Partner Live with Parents

Who lives in your home with you?

11. Work Situation: Working Unemployed Retired Homemaker Disabled Looking for work
Current or Former Occupation:

12. Hobbies, Interests, Types of Exercise:

13. What Town do you live in?

For how long?

If new to this area, Where did you previously reside?

14. About your children: Names	Age	Their Major Health Problems

15. Family Health History	Age	Major Health Problem, or cause of death if applicable
Your Mother		
Your Father		
Sisters(s)		
Brother(s)		
Other Medical problems that run in your family:		

16. Vaccinations	Year
Tetanus	
Hepatitis A	
Hepatitis B	
Measles	
Rubella	
Chicken Pox	
Flu	
Pneumonia	
Last TB test	
Other:	

Please use this space for overflow information:



Registration Form

PATIENT INFORMATION

Name: Last _____ First _____ MI _____
 Other Name(s) used: _____ Date of Birth: ____/____/____
 Home Address: _____ Social Security Number: _____
 City: _____ State: ____ Zip _____ Sex: M _____ F _____ Transgender _____

Mailing Address (if different from home address) Email Address _____

Address: (Street/or P.O Box) _____
 City: _____ State: _____ Zip _____

Home Phone #: _(____)____ - _____ Ok to leave message? **Brief** **Extended** **No**

Cell Phone #: _(____)____ - _____ Ok to leave message? **Brief** **Extended** **No**

Work #: _(____)____ - _____ ext. _____ Pharmacy Name: _____

Marital Status (please circle one) Single Married Divorced Widowed Separated Partner Other

RESPONSIBLE PARTY (If patient is a minor complete this section)

Name: Last _____ First _____ MI _____

Address (if different): _____ City: _____ State: _____ Zip _____

Home Phone #: (____)____ - _____ Date of Birth of Guardian: ____/____/____

Work Phone #: (____)____ - _____ Social Security of Guardian: _____

Relationship to patient: Mother _____ Father _____ Other _____

EMERGENCY CONTACT

Name: _____ Home Phone #: (____)____ - _____

Relationship: _____ Work Phone #: (____)____ - _____

PATIENT INSURANCE INFORMATION

Name of Insured	Primary Insurance Company Name	Secondary Insurance Company Name
Relationship to Patient	ID #	Group #

Payment Policy

The El Dorado Community Health Center is a primary healthcare organization. We depend on your prompt payment for services so that we can continue to provide quality, low-cost medical care for our community.
 We require payment at the time of service unless arrangements have been made with our billing department prior to the visit. We will bill your primary insurance carrier, but we do require you pay your co-payment and any deductible you have not met at the time of service. We will bill supplemental insurance for Medicare patients. Any amount due after your insurance pays its portion will be billed to you. Payment is due upon receipt of the statement. **You will be required to present your insurance card at each visit.**

PLEASE TURN OVER AND COMPLETE

Additional Patient Information

By answering the following questions, you will give us information we need to acquire grant funds to help uninsured and underinsured residents in our community. This information also help us recognize clients who may qualify for specially funded programs or services. El Dorado Community Health Center is a *non-profit organization* committed to serving the needs of our community. Please help us by providing us with this information. This information will become part of your confidential medical record.

(Please answer all questions)

Number of family members living in home: _____ Monthly income earned by family: _____

Employed: Full-time Yes ___ No ___ Part-time: Yes ___ No ___ Retired: Yes ___ No ___

Student: Full-time Yes ___ No ___ Part-time: Yes ___ No ___

Employer's Name: _____ Employer's Address: _____

May we contact you by phone? Yes _____ No _____ If no, How may we may we contact you? _____

Race: _____ American Indian/Alaska Native _____ Asian _____ Black/African American
_____ Hispanic or Latino _____ White _____ Native Pacific Islander
_____ Other Pacific Islander _____ Other _____ More than One race
_____ Unreported / Refused to report

Ethnicity: Hispanic/Latino: ___ Yes ___ No

What Language(s) do you communicate in? _____

What Language(s) do you prefer to communicate in? _____

Housing Type/Characteristic: Has patient been homeless at anytime since January of this year?

No ___ Yes ___ If yes, Homeless Shelter _____ Doubling Up _____ On Street _____

Do you work in one of the following area: Agricultural _____ Field Work _____

Are you a Veteran: Yes ___ No ___

CONSENT

In order to provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initialing the areas indicated and by providing your signature below.

1. Consent for Treatment: I hereby authorize and consent to procedures necessary for diagnosis and treatment for myself and my family while a patient at the El Dorado Community health Center. _____ (initials)
2. Release of Information: I authorize the release of medical information necessary to process billing claims related to my care. _____ (initials)
3. Assignment of Benefits: I authorize payment of medical benefits to El Dorado County Community Health Center for professional services rendered. _____ (initials)

Your signature below indicates you have read, understand and agree to the payment policy, and consents.

Signed: _____ Date: _____



Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Healthcare operations which include the business aspects of running our practice. Examples of this would include having a sign in sheet, calling to confirm appointments, leaving messages on your recorders regarding appointments, sending reminder/appointment cards in the mail with our practice name on them, using yours or a family members’ first and last name while servicing you in our office, discuss with/allow immediate family members/guardians into the exam process to allow for better understanding of treatment options when necessary.

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so, I documented the reason below:

Date: _____ Employee Initials: _____

Reason: _____