El Dorado Community Health Centers

Medical Tel: (530) 621-7700
Fax: (530) 621-7713
Dental Tel: (530) 497-5016
Fax: (530) 622-8908

Welcome to El Dorado Community Health Centers. We have three (3) office locations:

Office name	Location	Monday - Friday	Saturday
Placerville	4212 Missouri Flat Road, Placerville, CA 95667	8:00 am to 6:00 pm	Closed
Cameron Park Medical & Dental	3100 Ponte Morino Dr., Cameron Park, CA 95682	Medical 8:00 am to 8:00 pm Dental 8:00 am to 5:00 pm	9:00 am – 1:00 pm **Dental:** Call for appointment availability
Cameron Park Medical, STEPS & Pharmacy	3104 Ponte Morino Dr., Cameron Park, CA 95682	**Medical** 8:00 am to 6:00 pm **STEPS** 8:00 am to 6:00 pm **Pharmacy** 9:00 am to 5:30 pm	**Closed**

- **Medical and Behavioral Health Appointments: (530) 621-7700**
- **Dental appointments (Only in Cameron Park) (530) 497-5016**
- **Pharmacy information (Only in Cameron Park) (530) 556-2007**
- **For after hours on all services call (530) 621-7700**

Please arrive on the day and time listed on the appointment card listed below. If you are not able to keep this appointment, you must call in advance to reschedule or cancel.

Enclosed are the following forms: **Patient Information Sheet, Health Questionnaire, and a Privacy Consent**. Please complete the enclosed forms and *bring them to your first appointment*.

Other important items to bring are:

- Current medications and/or vitamins you may be taking
- Current insurance coverage cards
- Previous medical records, previous doctor's addresses and phone numbers
- Immunization Records
- Valid Photo ID (Drivers Lic, Passport, Student ID)
- Any legal medical paperwork including, advanced directives and guardianships.

We participate in most major medical insurance plans and will file a claim to them as a courtesy. 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 Centers.***

If you have questions, please call us at 530-621-7700. Once you have established as a patient at one of our locations, an on-call provider is available by phone after hours to answer health related questions.

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

Sincerely,
The Staff and Providers at
El Dorado Community Health Centers

New Patient Appointment:

Name:_____

Mon ▪ Tues ▪ Wed ▪ Thurs ▪ Fri

Check In Time: _____

Appt. _____ at _____am / pm

With: _____

El Dorado Community Health Center Location:

Placerville ▪ Cameron Park

EDCHC
El Dorado Community Health Centers

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PATIENT INFORMATION

Name: Last name | First Name | Middle Name Other Name(s) used: _____

Mailing Address: Street | City | State | Zip

Home Phone (___) ___-_____ Cell (___) ___-_____ Work (___) ___-_____ ext.____

Primary Phone (please select one): ☐ Home ☐ Cell ☐ Work Leave Brief Message: ☐ Home ☐ Cell ☐ Work

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening Leave Extended Message: ☐ Home ☐ Cell ☐ Work

Preferred Language: _____

Please choose **one** preferred method of communication from EDCHC below. This would include appointment reminders, general notifications and health reminders. You retain the ability to opt out of this service at any time:

☐ **Automated Calls** **OR** ☐**Text Notifications (text messaging & data rates may apply)**

Electronic Communication Acknowledgement: I understand and agree that the requested communication method is not secure once it has been transmitted to me, making my Personal Health Information (PHI) at risk for receipt by unauthorized individuals in the event of a stolen or lost phone. I accept full responsibility of my phone and I will not retaliate against the practice in any way should this occur. Initials _____

Patient Date of Birth: MM/DD/YYYY Gender on birth certificate ☐ Male ☐ Female SSN: _____-____-_____

Marital Status (please mark one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

RESPONSIBLE PARTY

Full name:_____

Date of Birth of Parent/Guardian: ___/___/___

Address (if different): _____

City: _____ State: _____ Zip _____

Primary Phone #: (_____) _____-_____

SSN of Parent/Guardian: _____

Relationship to patient:

☐ Mother ☐ Father ☐ Other_____

RESPONSIBLE PARTY

Full name:_____

Date of Birth of Parent/Guardian: ___/___/___

Address (if different): _____

City: _____ State: _____ Zip _____

Primary Phone #: (_____) _____-_____

SSN of Parent/Guardian: _____

Relationship to patient:

☐ Mother ☐ Father ☐ Other_____

EMERGENCY CONTACT (If patient is a minor, other legal guardian not listed above)

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

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

Address: Street | City | State | Zip

Do you have an Advanced Directive for Health Care? ☐ Yes ☐ No ☐ Interested

If yes, please provide a copy of your Advanced Directive to the front desk *Office Use*: ☐ Info Given

STREET ADDRESS (*If different from mailing above*)

Address: Street | City | State | Zip

Would you like access to your medical provider team and medical records online? ☐ Yes ☐ No

If yes, registration through a secure email link is required. Private Email Address:_____

Preferred Lab Company: ☐ Marshall Lab ☐ Quest Lab ☐ Other: _____

Preferred Imaging Company: ☐ Marshall Imaging ☐ Other: _____

Preferred Pharmacy Name**:** _____ Location:_____

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Additional Patient Information

El Dorado Community Health Center is a *non-profit organization* committed to serving the needs of our community. The information you provide can help us recognize clients who may qualify for specially funded programs or services.

Special Population Designation:	
1. In the last 2 years, have you or anyone in your family, worked in any type of agriculture (farm work) like: planting, picking, preparing the soil, packing house, driving a truck for any type of farm work, worked with animals like cows, chickens, etc.	☐Yes ☐No
2. In the last 2 years, have you or a member of your family lived away from home in order to work in any type of agriculture (farm work)?	☐Yes ☐No
3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age (too old to do the work)?	☐Yes ☐No
4. Are you a U.S. Veteran?	☐Yes ☐No
5. Would you consider yourself homeless at any time in the last 12 months? If Yes, where: ☐ In your car ☐ On the street ☐ In a shelter ☐ With another family ☐ In a hotel ☐ Other_____	☐Yes ☐No
6. Are you currently in a public housing or low-income housing program?	☐Yes ☐No

7. Total number of people living in household_____
Approximate total yearly income earned by family household $_____
(do not include Social security or disability payments)

8. Sexual Orientation:
☐ Heterosexual (Straight - not lesbian or gay) ☐ Homosexual (Lesbian or Gay) ☐ Bisexual
☐ Choose not to disclose ☐ Do not know ☐ Something Else Describe:

9. Gender you identify with:
☐ Male ☐ Female ☐ Other_____ ☐ Choose to not disclose
☐ Transgender Male (Female-to-Male), Date of Transition: _____
☐ Transgender Female (Male-to-Female), Date of Transition: _____
Gender queer, neither exclusively male nor female
Additional gender category or other, please specify:_____

10. Race:
☐ American Indian/Alaska Native ☐ Native Hawaiian
☐ Asian ☐ Other Pacific Islander
☐ Black/African American ☐ Other Race
☐ Declined to Specify ☐ White

11. Ethnicity (mark one): ☐ Hispanic/Latino: ☐ Non-Hispanic/Latino ☐ Declined to Specify

12. Employer's Name: _____ Employer's City/Location: _____
Work Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Unemployed ☐ Retired ☐ Homemaker
☐ Disabled ☐ Currently Looking ☐ Student ☐ Other:_ _____

13. Where did you hear about our services?
☐ Family or Friend ☐ Radio Ad
☐ Local Hospital ☐ TV
☐ Newspaper/Magazine ☐ Social Media (Facebook, Twitter, Instagram)
☐ Yellow Pages ☐ Someone handed me a Business Card
☐ County Agency ☐ Insurance Company
☐ EDCHC Booth or event ☐ Dental Van

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PATIENT INSURANCE INFORMATION

Primary Insurance Company Name:	**Secondary Insurance Company Name:**
Insurance Subscriber:	Insurance Subscriber:
Relationship to Patient:	Relationship to Patient:
ID #: Group #:	ID #: Group #:

Uninsured patients may be eligible to receive a discount through the sliding fee program. Discounts are based off family size and household income. Our staff can help you with questions regarding health care and dental care plans.

PAYMENT POLICY

The El Dorado County Community Health Centers is a private primary health care organization. We depend on your prompt payment for services so that we can continue to provide low-cost medical care for our community. 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. We require payment at the time of service unless arrangements have been made with our billing department prior to the visit.

CONSENT

In order to provide treatment, coordination of clinical care, 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 (or child/dependent stated above) while a patient at the El Dorado Community Health Centers. _____ **(initials)**
2. Release of Information: I authorize the release of information collected by the center necessary for a coordination of clinical care and to process billing claims related to my care (or child/dependent stated above). _____ **(initials)**
3. Assignment of Benefits: I authorize payment of medical benefits to El Dorado Community Health Centers for professional services rendered. _____ **(initials)**

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

Signed: _____ **Date:** _____

Printed Name: _____ Relationship to Patient: _____

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

Today's Date:_____

Your Name_____ Date of Birth_____

1. Your current or previous Primary Physician: Name:	**Address:**	**Phone:**

2. Specialists	**Reason?**	**Specialist Address:**	**Specialist Phone:**
a._____	a. _____	a._____	a. _____
b._____	b._____	b._____	b._____

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

Please bring all your medication(s) 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: □ Never used tobacco (smoke or chew)**
Mammogram, Breast exam		N	Abn	□ Cigarettes # packs/ day # of years
Pap Smear		N	Abn	□ Chew tobacco
Colonoscopy or Sigmoidoscopy		N	Abn	□ I Quit ! When:
Fecal occult blood test		N	Abn	□ I want to quit
Prostate exam		N	Abn	
PSA		N	Abn	**8. Alcohol use: □ None**
Cholesterol test		N	Abn	Types: □ Wine, □ Beer, □ Hard liquor
Blood Glucose		N	Abn	# drinks: per □ Day, □ Week, □ Month
Other:		N	Abn	
		N	Abn	**9. Other Recreational Drugs used: □ Never used**
		N	Abn	Types:

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7. 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:		

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

Please use this space for overflow information:

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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:_____

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Patient Rights and Responsibilities

As a patient of our Health Center, you have the right to:

- Considerate and respectful care, without unlawful discrimination
- Know the name and professional qualifications of the medical providers involved in your treatment
- Choose your medical provider(s)
- Receive accurate, understandable information regarding any proposed treatment or procedure in order to make an informed health care decision.
  Information provided shall include:
  - A description of the treatment or procedure.
  - The medically significant risks involved.
  - Alternative courses of treatment or non-treatment and the risks involved in each.
- Fully participate in decisions regarding your medical care
- Confidentiality and the protection of privacy concerning your medical care program and medical records or other personal health information. you have the right to be advised as to the reason for the presence of any individual present during examinations or during discussions about your medical information.
- Access, review, and/or copy your medical records in accordance with applicable law
- Receive an itemized bill for services and an explanation of charges, including services that will be charged to your insurance, as applicable
- Have complaints or concerns reviewed in accordance with our established process, without fear of retaliation or sanction.

As a patient of our Health Center, you assume responsibility for:

- Being considerate and respectful to our staff and your fellow patients
- Providing accurate and complete information concerning your present medical concerns, past medical history, and other matters relating to your health
- Participating and working collaboratively with your medical providers in developing your treatment plan
- Making it known whether you understand your medical treatment and what is expected of you
- Following the treatment plan established by the medical providers involved in your care
- Keeping appointments and notifying the office in a timely manner if you are unable to keep an appointment
- Abiding by our policies and procedures, as well as those of any applicable insurer or government benefits program
- Providing accurate and correct demographic and financial/insurance information
- Fulfilling the financial obligations related to your treatment
- Supervising your children while in the Health Center (if a parent or guardian)

I have read and understand the Patient Rights and Responsibilities:

Patient/Guarantor Signature: _____ Date: _____