EDCHC
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

Medical Locations & Office Hours	
Placerville – 4212 Missouri Flat Road, Placerville CA, 95667	
Monday - Friday: 8:00 am – 12:00 pm, 1:00 pm – 5:30 pm	**Saturday:** 9:00 am to 1:00 pm
Cameron Park 1 – 3104 Ponte Morino Dr. STE 110, Cameron Park, CA 95682	
Monday – Friday: 8:00 am – 12:00 pm, 1:00 pm – 5:00 pm	**Saturday:** CLOSED
Cameron Park 2 – 3100 Ponte Morino Dr. STE 120, Cameron Park, CA 95682	
Monday – Friday: 8:00 am – 12:00 pm, 1:00 pm – 5:30 pm	**Saturday:** CLOSED

Before Your Appointment

Please arrive 30 minutes early to complete the check-in process. If you need to cancel or reschedule, please call us at least 24 hours in advance.

What to Bring to Your Appointment

- **Completed Forms:** Patient Registration, Medical History Form.
- Current **insurance coverage** card(s).
- Valid **Photo ID** (Drivers Lic, Passport, Student ID).
- Any **legal medical paperwork** including Advanced Directive and guardianship documentation.
- Current **medications and/or vitamins** you are taking.
- **Immunization** (Vaccine) Records

Insurance, Copays & Payments

We participate with most major medical insurance plans. Co-payments and deductibles are due at the time of service and may be paid by cash, check, Visa, or MasterCard.

Uninsured patients may be eligible to receive a discount through the Sliding Fee Program. Discounts are based on family size and household income.

Please note that we do not participate in Workers' Compensation cases and do not bill Motor Vehicle Accident (MVA) insurance.

Contact Us

If you have questions, please call us at 530-621-7700.

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.

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PATIENT INFORMATION

Name: _____ Other Name(s) used: _____
Mailing Address: _____
Street Address: _____
Cell Phone (____) _____-_____ Alternative Phone: ☐ Home ☐ Work (____) _____-_____
Can we text you? ☐Yes ☐No Can we leave a voice message? ☐Yes, Brief ☐Yes, Extended ☐No
Email Address: _____ Patient Portal Access: ☐ Yes ☐ No
Preferred Language: _____ Date of Birth: ____/____/_____ SSN: _____ -___-____
Gender Assigned at Birth: ☐ Male ☐ Female
Marital Status (please mark one): ☐Single ☐Married ☐Divorced ☐Widowed ☐Separate ☐Other
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

RESPONSIBLE PARTY *(If the patient is a minor - parent or legal guardian complete this section.)*

Name: _____ Relationship: ☐Mother ☐Father ☐Other: _____
Phone: ☐Home ☐Cell ☐Work (____) _____ - _____ SSN of Parent/Guardian: ____ -___-_____
Date of Birth: _____ ☐ Emergency Contact

INSURANCE

Insurance Carrier: _____
ID/Policy number: _____
Group Name/Number: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Cell (_____) _____-_____ Alternative Phone: ☐Home ☐Work (_____) _____-_____

PHARMACY

☐ EDCHC Placerville Pharmacy – 4212 Missouri Flat Road, Placerville
☐ EDCHC Cameron Park Pharmacy – 3104 Ponte Morino Drive STE. 100, Cameron Park
☐ Other Pharmacy Name/Location: _____

LAB AND DIAGNOSTIC IMAGING

Preferred Lab Company (select one): ☐ Quest Lab ☐ Marshall Lab ☐ Other: _____
Preferred Imaging Company: ☐ Marshall Imaging ☐ Other: _____

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ADDITIONAL INFORMATION

1. **Are you a U.S. Veteran? *** ☐ Yes ☐ No

2. **Would you consider yourself unhoused at any time in the last 12 months? *** ☐ Yes ☐ No
   If yes, where have you stayed? ☐ In your Car ☐ In a hotel ☐ With Family/Friend
   ☐ In a Shelter ☐ On the Street ☐ Other: _____

3. **Are you currently in a public housing or low-income housing program? *** ☐ Yes ☐ No

4. **Total number of people living in household**:* _____
   Total yearly income earned by family household*: $ _____. ___
   (Does not include Social Security or Disability payments)

5. **Pronouns:**
   ☐ He/Him/His/Himself ☐ She/Her/Hers/Herself ☐ They/Them/Their/Themselves
   ☐ Ze/Zem/Zir/Zirself ☐ Xie/Hir/Hirs/Hirself ☐ Other (please specify): _____

6. **Sexual Orientation:**
   ☐ Heterosexual (Straight - not lesbian or gay) ☐ Homosexual (Lesbian or Gay) ☐ Bisexual
   ☐ Choose not to disclose ☐ Do Not Know ☐ Other (please specify): _____

7. **Gender you identify with:**
   ☐ Male ☐ Female ☐ Choose to not disclose ☐ Other (please specify): _____
   ☐ Gender queer (neither exclusively male nor female)
   ☐ Transgender Male (Female-to-Male) Date of Transition: _____
   ☐ Transgender Female (Male-to-Female) Date of Transition: _____

8. **Race**:
   ☐ American Indian/Alaska Native ☐ Guamanian or Chamorro ☐ Samoan
   ☐ Asian Indian ☐ Japanese ☐ Vietnamese
   ☐ Black/African American ☐ Korean ☐ White
   ☐ Chinese ☐ Native Hawaiian ☐ Other Race: _____
   ☐ Filipino ☐ Other Pacific Islander ☐ Declined to Specify

9. **Ethnicity (choose one):**
   ☐ Chicano ☐ Mexican American
   ☐ Cuban ☐ Puerto Rican
   ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
   ☐ Mexican ☐ Declined to Specify
   ☐ Other Hispanic, Latino, or Spanish Origin (please specify): _____

10. **Work Status: *** ☐ Employed Full-Time ☐ Employed Part-Time ☐ Not Employed
    ☐ Self-Employed ☐ Retired ☐ Other: _____
    Employer's Name*: _____ Employer's City/Location*: _____

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11. How did you hear about us? ☐Family Member ☐Friend ☐EDCHC Signage/Mobile Service ☐ Another Agency ☐ Social Media ☐Internet ☐Event/Booth ☐ Newspaper/TV/Radio

12. Do you have a dentist? ☐ None
☐ EDCHC Dentist, last visit date: _____ ☐ Other Dentist, last visit date: _____

13. Do you have an Eye Care provider? ☐ None
☐ EDCHC Eye Care, last visit date: _____ ☐Other Eye Care Specialist, last visit date: _____

PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT

I have read and understand the Patient's Rights and Responsibilities. I acknowledge my responsibility to uphold these principles and comply with the guidelines outlined. www.edchc.org **Initials:** _____

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 include appointment confirmation calls, voicemail messages, letters to home address, discuss with/allow immediate family members/guardians into the exam process to support the understanding go the treatment options when necessary.

I acknowledge that I have received and reviewed the Notice of Privacy Practices, which explains how my personal health information may be used and disclosed. I understand my rights regarding this information and how I can access it. The Notice of Privacy Practices is available at the front desk, upon request, and by visiting www.edchc.org. **Initials:** _____

PATIENT INFORMATION GUIDE

I have read and understand the Patient Information Guide. I acknowledge my responsibility to follow the guidelines, policies, and expectations outlined within it. www.edchc.org **Initials:** _____

AI DICTATION

El Dorado Community Health Centers may use AI technology to improve the efficiency and accuracy of documenting my health information. The AI system is used to assist in transcribing medical notes and all information is handled securely in compliance with privacy regulations, including HIPAA. If I consent, my health information will be protected, and access to the AI documentation will be limited to authorized personnel only.

SLIDING FEE DISCOUNT PROGRAM

As an FQHC, our Centers offer a sliding fee program based on family size and household income. Our staff can help you with questions regarding sliding fee discount program.

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PAYMENT POLICY

As a private organization committed to providing affordable, high-quality care to our community, we rely on prompt payment for services rendered.

Insurance Billing: We will bill your primary insurance carrier on your behalf. For Medicare patients, we will also bill your supplemental insurance when applicable.

Payment Responsibilities:

- Co-pays and unmet deductibles are due at the time of service.
- Any remaining balance after your insurance has paid will be billed directly to you.
- Payment is due upon receipt of your billing statement.

Insurance Card/Sliding Fee Discount Program Card Requirement: Please present your current insurance or Sliding Fee Discount Program card at each visit to ensure accurate billing.

Payment Arrangements: If you are unable to pay at the time of service, you must contact our billing department in advance to discuss payment arrangements.

CONSENT

To provide medical treatment, coordinate your clinical care, bill your insurance, or release information required by your insurance carrier, we must obtain your consent. Please read the statements below, initial each section to indicate your understanding and agreement, and sign at the bottom of the form.

1. **Consent for Treatment:** I authorize and consent to all necessary medical evaluations, procedures, and treatments for myself (or for my child/dependent listed above) while receiving care at El Dorado Community Health Centers. **Initials:** _____
2. **Release of Information:** I authorize El Dorado Community Health Centers to release any medical or other information required for coordination of clinical care and for billing purposes, including submission of claims to my insurance provider for myself (or my child/dependent listed above). **Initials:** _____
3. **Assignment of Benefits:** I authorize payment of medical benefits directly to El Dorado Community Health Centers for services provided to me or to my child/dependent listed above. **Initials:** _____

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

Signature: _____ **Date:** _____

If signed by someone other than patient, complete below:

Print name: _____

By signing, I attest that I have authority under applicable law to act for the patient with respect to the information and timeframe described in this authorization.

Legal authority to request/access records: (select one): ☐ Parent/Legal Guardian ☐ Conservator ☐ Agent under Health Care Power of Attorney ☐ Executor/Personal Representative of Estate ☐ Other (specify): _____

Documentation: (attach if applicable): ☐ Health Care Power of Attorney ☐ Court Order ☐ Letters of Conservatorship ☐ Other: _____

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Please complete this medical history form so we can better understand your health needs.

Today's Date: _____

Patient's Full Name: _____ Date of Birth: _____

Primary Insurance: _____ Secondary Insurance: _____

1. Who is your current or previous Primary Physician? Please add their information below.

Name:	Address:	Phone:

2. Medical conditions and treatments (past and present): ☐ None

If applicable, please list them below.

Medical Condition:	Year of Onset	Surgeries You Have Had:	Date:

3. Do you currently see any medical specialists? ☐ Yes ☐ No If yes, please list them below.

Specialist Name:	Reason for Consult(s):	Specialist Address:	Specialist Phone:

4. Do you have any allergies to food or medication? ☐ Yes ☐ No If yes, please list them below.

Name of Allergen(s):	Type of reaction:

5. Do you currently take any medications, vitamins, or herbal supplements? ☐ Yes ☐ No

If yes, please list them below and bring them to your appointment.

Medication Name:	Dose (mg/mL/u):	How many times a day?	Prescribing Doctor:

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6. Which preventive health tests have you had? ☐ None

If you have completed any of the tests listed, enter the year and result. Use the "Other" fields for tests not listed. Check "None" if none.

Test Name:	Year	Normal	Abnormal	Test Name:	Year	Normal	Abnormal
Mammogram		☐	☐	Cholesterol		☐	☐
Pap Smear		☐	☐	Hemoglobin A1c		☐	☐
Colonoscopy		☐	☐	Other:		☐	☐
FIT Test or Cologuard Test		☐	☐	Other:		☐	☐
Prostate-Specific Antigen (PSA)		☐	☐	Other:		☐	☐

7. Tobacco use (chew or smoke)**?** ☐ Yes ☐ Never If yes, please provide details below.

☐ Cigarettes: ___ packs/day, ___ years ☐ Chew tobacco ___ years.
☐ I quit: _____ (when?) ☐ I want to quit.

8. Alcohol Use: ☐ Yes ☐ None If yes, please provide details below.

Type(s):	☐ Wine ☐ Beer ☐ Hard Liquor	# of Drinks:		Frequency:	☐ Day ☐ Week ☐ Month

9. Recreational Drug Use: ☐ Yes ☐ Never

If yes, please list drug name(s) and last use: _____

10. Does anyone in your immediate family have a history of medical conditions? ☐ Yes ☐ No

If yes, please provide details below. (Include biological relatives only, names are not required.)

Family Member:	Age:	Deceased? (Y/N)	Major health problem, or cause of death if applicable:
Mother			
Your Father			
Sisters(s)			
Brother(s)			
Other medical problems that run in your family:			

11. Have you received any vaccinations? ☐ Yes ☐ No

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If yes, enter the year received for the vaccines below. Use the 'Other' fields for vaccines not listed.

Vaccine Name:	**Year**	**Vaccine Name:**	**Year**	**Vaccine Name:**	**Year**
Tetanus (Td/Tdap)		Varicella (Chicken Pox)		Coronavirus Disease (COVID)	
Hepatitis A (Hep A)		Influenza (Flu)		Last Tuberculosis Test (TB)	
Hepatitis B (Hep B)		Pneumococcal (Pneumonia)		Other:	
Measles		Shingrix		Other:	
Rubella		Respiratory Syncytial Virus (RSV)		Other:	

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EDCHC AUTHORIZATION FOR THE RELEASE OF INFORMATION

Print Patient's Name: _____ Date of Birth: _____

I authorize El Dorado Community Health Centers (EDCHC) to discuss and share my protected health information with the following person:

Name: _____ **Relationship**: _____ **Phone**: _____

Purpose of authorization: _____
Examples include care coordination, billing inquiry, personal support, and legal or insurance matters; this is not an all-inclusive list of PHI that may be shared.

Please share the following information:
☐ Medical ☐ Dental ☐ Eye Care ☐ Chiropractic ☐ Behavioral Health
☐ Psychiatry ☐ STEPS/Substance Use Disorder (SUD) Treatment ☐ Billing

By initialing below, I authorize EDCHC to share my sensitive information

_____ Alcohol/Drugs/Substance Use Disorder (SUD) Treatment
_____ Behavioral Health
_____ Psychiatry
_____ Reproductive Health
_____ HIV/AIDS
_____ Genetic Information

*Psychotherapy notes Exclusion: This authorization does not permit disclosure of Psychotherapy notes as defined by HIPAA.

EXPIRATION: This authorization expires on (date): ____/____/_____ unless revoked earlier in writing or upon my death.

Acknowledgement and Understanding

- I understand that this authorization is in effect until the expiration date listed above, until I revoke it in writing, or upon my death.
- I understand that authorizing the release of my protected health information is voluntary, and I have the right to refuse to sign this authorization. My refusal will

not affect my ability to receive treatment, nor will it impact my payment, enrollment, or eligibility for benefits.

- I understand I may revoke this authorization at any time by submitting a written revocation to EDCHC. Revocation does not affect disclosures made in reliance on this authorization before EDCHC receives my revocation.
- I understand I have the right to receive a copy of this authorization.
- This authorization does not permit the request or release of copies of my health records; a separate Release of Records form is required.
- This authorization does not authorize healthcare decision-making.
- This authorization does not authorize consent for treatment of a minor; a separate Consent to Treat form is required.
- I understand that once information is shared with the authorized recipient, it may no longer be protected by HIPAA. California law generally prohibits further disclosure without my authorization or as required/permitted by law; certain categories (HIV test results, behavioral health, psychiatry, substance use disorder (SUD) treatment, reproductive health, and genetic information) have additional restrictions.

If Applicable:

- For minors and sensitive services: if the patient is a minor, information for certain services the minor may consent to (e.g., reproductive health, STI care, outpatient mental health counseling, and substance use disorder services) may require the minor's authorization and may not be shared with a parent/guardian unless permitted by law.
- Substance Use Disorder (SUD) Treatment Information. If SUD information protected by 42 C.F.R. part 2 is authorized to be released, fill in the following:

  Recipient (name/class): _____

  What kind of information: _____

  How much and/or timeframe: _____

  Purpose: _____

  You may revoke in writing at any time (except to the extent already relied upon). A Part 2 prohibition-on-redisclosure notice will accompany any disclosure.

Contact for Questions/Revocations:

Health Information Management
4212 Missouri Flat Road, Placerville, CA 95667
Phone: 530-621-7700 ext. 2030 Email: medicalrecords@edchc.org

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RELEASE OF INFORMATION

Signature: _____ **Date:** _____

If signed by someone other than patient, complete below:

Print Name: _____

By signing, I attest that I have authority under applicable law to act for the patient with respect to the information and timeframe described in this authorization.

Legal Authority (select one): □ Parent/Legal Guardian □ Agent under Health Care Power of Attorney □ Conservator □ Executor/Personal Representative of Estate □ Other (describe): _____

Documentation: (attach if applicable): □ Health Care Power of Attorney □ Letters of Conservatorship □ Court Order □ Other: _____