# *Laguna Community Health Center*
# *Parental Consent for Treatment Form For Minor Patients*
*(Less Than 18 Years Of Age)*

Patient's Name: _____ LCHC HRN: _____

I, _____, acknowledge I am the Parent/Legal Guardian of the above named patient. I certify that the patient is a minor and I am the parent/guardian authorized to submit this consent.
I cannot accompany my child, (insert child's name) _____, to the Laguna Community Health Center (LCHC). Therefore, I hereby authorize, (insert name) _____, _____, _____ , as follows:

- ☐ To seek general medical treatment for my child as described in the LCHC Informed Consent and to provide consent for such treatment if attempts to contact me are unsuccessful.
- ☐ To seek general medical treatment for my child as described in the LCHC Informed Consent and to provide consent for such treatment without having to contact me.

**Expiration of Designation (check one):**

- ☐ This form will remain in effect until revoked- see "Notice to Revoke Designation of Another Person to Consent for Treatment" Form
- ☐ This form is VALID ONLY during the following timeframe:

Effective Date: _____/ Expiration Date: _____

I understand I will need to complete a separate Release of Information Form if I require a copy of my child's records. No records shall be given without my written consent. I understand this form is effective until my child reaches the legal age of 18 or revoked by the parent or legal guardian.

**By signing this form, I certify that the Laguna Community Health Center may share any protected health information related to the care of my child with the person I have designated above.**

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of LCHC Staff Witness Date

Address: _____

Contact Phone Numbers: _____

**LCHC Patient Registration ONLY**

**Received By (Staff name):** _____ Date: _____

*Laguna Community Health Center*

***New Patient Registration Form***

(Please Complete One Form For Every New Patient. Present This Form Along With Required Documents To Establish Your Patient Record)

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ City of Birth: _____ State of Birth: _____

Sex: Male ____Female ____ Other, Please Specify: _____

Marital Status: _____ Religious Preference: _____

Physical Address (*No P.O. Box*): _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____ Message Phone: _____

Date Moved To This Address: _____ Community/Village of Residence: _____

Tribal Affiliation: _____ Tribal Blood Quantum: _____

Tribal Enrollment Number: _____ Other Tribal Affiliation: _____

Other Tribal Blood Quantum: _____ Hispanic/Not Hispanic: _____

Mother's Name: _____ Mother's Maiden Name: _____

Mother's City of Birth: _____ Mother's State of Birth: _____

Father's Name: _____ Father's City of Birth: _____

Father's State of Birth: _____

Mother's Employer: _____

Employer Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____

Father's Employer: _____

Employer Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____

**LCHC Staff Use Only:**

Health Record Number: _____

Updated 04/2024

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Next of Kin: _____ Relationship to Patient: _____

Next of Kin Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Medicare: Yes ____ No ____ If yes, What is your Medicare MBI #: _____

Medicaid: Yes ____ No ____ If yes, Are You Enrolled In A Centennial Care Plan? Yes ____ No____

Blue Centennial Care: _____ Presbyterian Centennial Care: ____ Western Sky: ____

Please Provide Your ID #: _____

Private Insurance: Yes ____ No ____ If yes, Name of Insurance Plan: _____

Policy Holder: _____ Date of Birth: _____

Insurance ID #: _____ Group ID: _____ Start Date: _____

Are You A Veteran? Yes ____ No____ If Yes, What Branch? _____

Do You Have A Valid VA Card? Yes ____ No ____ Are You Service Connected? Yes ____ No ____

Do You Have Access To The Internet? Yes ____ No ____ If Yes, Where? _____

What Is Your Email Address? _____

What Is Your Communication Preference? Phone ____ Mail ____

**I understand an Electronic Health Record will be created at the Laguna Community Health Center. I certify the above information is true to the best of my knowledge and no information is deliberately falsified.**

_____ _____

Signature of Parent/Legal Guardian Today's Date

**LCHC Staff Use Only:**

Health Record Number: _____

Updated 04/2024

Laguna Community Health Center
PO Box 1407
6 Basswood Road
Laguna, NM 87026

# MEDICAL SERVICES AGREEMENT

1. AUTHORIZATION FOR CARE AND TREATMENT: By signing this, I voluntarily agree to treatment and services that any Laguna Community Health Center (LCHC) provider deems necessary. **Initial:** _____

2. RELEASE OF INFORMATION BILLING PURPOSES AND REVIEW: By signing this, I allow LCHC to release Protected Health Information (PHI) about my medical care to any person or entity for the purpose of billing for my care. LCHC will not release my medical history, mental or physical condition, alcohol/drug abuse and Psychiatric diagnosis for the purposes of billing for my care. **Initial:** _____

3. PURCHASED REFERRED CARE (PRC): I fully understand my role and responsibility under the Contract Health Services (CHS) regulations. I understand that PRC is not an insurance or an entitlement program. I must notify PRC within 72 hours or obtain Prior Approval for PRC services. I understand that I must comply with the regulations outlined under the alternate resource notice. **Initial:** _____

4. TRIBAL AFILIATION: To verify that I am eligible to receive PRC services and funding, LCHC staff will verify my Laguna Tribal affiliation. **Initial:** _____

5. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to LCHC of insurance benefits otherwise payable to me from private insurance, Medicare, Medicaid, liability claims, and/or reimbursable insurance for the services I receive. **Initial:** _____

6. MEDICAID: I agree to present a current Medicaid identification card every time I receive services, as required by State of New Mexico regulations. **Initial:** _____

7. MEDICARE: By signing this agreement, I have given LCHC a "Statement of Permit for Payment of Medicare Benefits to this Provider". **Initial:** _____

8. NON-BENEFICIARY FINANCIAL AGREEMENT: Eligible LCHC employee non-beneficiaries who receive LCHC services under LCHC's services to Non-Beneficiaries Policy agree to pay the LCHC on a fee-for-service, full-cost-recovery basis and/or complete a sliding scale fee application. Any co-pays and deductibles required by an insurance provider, or any cost denied by an insurance or benefits provider are the responsibility of the patient, or in the case of a minor, the parent/guardian. Payment of the co-pay is required before services are rendered and must be made

by credit card or check. Other Payments will be directly billed to you, and the payment is expected withing 30 days of receiving your bill. **Initial:** _____

9. PATIENT RIGHTS AND RESPONSIBILITIES: My rights and responsibilities as a patient have been explained to me. I have been given and read this Medical Services Agreement/Notice of Privacy practices and have signed the Receipt of Notice of Privacy Practices. I understand that I can ask LCHC staff questions about my rights. **Initial:** _____

AGREEMENT: By signing this form, I understand its contents and have received a copy. This agreement was explained to me in English or my native language. I understand that this document is part of my medical record and will be renewed on an annual basis.

_____ _____

Patient/Guardian/Guarantor's Signature Date

_____ _____

Interviewer's Signature Date

**YOUR RIGHTS:**

- You have the right to respect, privacy, and confidentiality. You have the right to have your own spiritual and cultural beliefs respected.
- You have the right to actively participate in decisions about your care and treatment. Parents/Guardians have the right to actively participate in all aspects of care for infants, children, and individuals who are mentally confused or incompetent.
- You have the right to information and education from your healthcare practitioner, including information about your treatment and risks to your health. You have a right to have an interpreter provided in your native language. If your hearing is impaired, you have the right to assistance from a practitioner who understands hearing impairment.
- You have the right to refuse treatment except in critical situations.
- You have the right to have private medical examinations and confidential records. You may refuse observers, and you have the right to exclude family members from your examination or explanation of treatment.
- You have the right to receive care in a secure and safe environment. You also have a right to have the services required for your treatment if available and permitted for your condition.

  **Initial:** _____

**YOUR RESPONSIBLITES:**

Follow the doctor's instructions. Take your prescribed medicine. Make and keep your appointments. Contact LCHC PRC staff within 72 hours or obtain Prior Approval to obtain PRC services. Ask questions and be informed. **Initial:** _____

Patient Print name: _____ Medical Record Number: _____

Interviewer Print name:_____ Scanned into Record date:_____



**Form approval:** 04/28/2023 CS

Laguna Community Healthcare Center

# NOTICE OF PRIVACY PRACTICES

## THIS NOTICE DESCRIBES:

• How health information about you may be used and disclosed

• Your rights with respect to your health information

• How to file a complaint concerning a violation of the privacy or security of your health information, or of your rights concerning your information.

**You have a right to a copy of this notice (in paper or electronic form) and to discuss it with the Compliance Officer: Sherry Heath at 505-431-0711 and sheath@lagunahealthcare.org if you have any questions.**

## PRIVACY POLICY

Laguna Community Healthcare Center (LCHC) understands that medical information about you and your health is personal. We are committed to protecting medical information about you. Laguna Community Healthcare Center creates a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices applies to all the records of your care generated and/or maintained By Laguna Community Healthcare Center including the following people and organizations:

♦ Any health care professional who is authorized to enter information in your medical record
♦ Any member of a volunteer group that we allow to help you while you are receiving services

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

## LAGUNA COMMUNITY HEALTHCARE CENTER WILL:

♦ Make sure that medical information that identifies you is kept private
♦ Make sure that you are given notice of our legal duties and privacy practices with respect to medical information about you
♦ Make certain That Laguna Community Healthcare Center follows the terms of the notice that is currently in effect

## HOW WE MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following information describes different ways we use and disclose medical information. If you are receiving services for the evaluation or treatment of substance abuse conditions, specific rules apply to the use and disclosure of information related to those services. Please refer to the section entitled Substance Abuse Health Information for those rules.

Protected Health Information (PHI) means "individually identifiable health information" that is maintained or transmitted in electronic form or in any other form, including media, paper or oral. PHI includes demographic information, identifiers (name, address, birth date, Social Security Number) and health

information regarding your physical or mental health or conditions, including past or present provision of health care to you, or information regarding payment for your health care. 45 C.F.R. § 160.103. PHI Is described as medical information in this notice.

**FOR TREATMENT:** We may use medical information about you to provide you with behavioral health treatment or services. We may disclose information about you to psychiatrists, therapists, case managers, your primary care physician, and other behavioral health professionals involved in your care. For example, a physician may need to know what psychiatric medications you are using to coordinate care, or we may need to speak to the pharmacist about your prescriptions. Different departments or groups within our health center may also share information to coordinate the services you need, such as medications, individual therapy, group therapy, case management and vocational services. We may ask for you to authorize the release of medical information for some treatment disclosures, even though it is not required, as a way to inform and involve you with the course of your treatment.

**FOR PAYMENT:** We may use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from appropriate payers, including Medicaid, a private insurance company or a third party. For example, we may need to give your insurance company medical information about treatment you received at the health center so that your insurer can make payment. We may also need to tell your provider agency about any services you are going to receive to obtain prior approval or to determine whether your insurance will cover the services.

**FOR HEATHCARE OPERATIONS:** We may use and disclose medical information about you for the business activities of Laguna Community Healthcare Center. These uses and disclosures are necessary for administrative functioning and to ensure our patients receive quality care. For example, we may send you a member satisfaction survey to determine how we can improve services. We may disclose medical information about you to evaluate the quality of services we provide or to resolve a specific treatment issue you have raised.

**INDIVIDUALS INVOLVED IN YOUR CARE:** We may release medical information about you to a family member actively involved in your care and treatment in accordance with our policies and procedures, and as authorized by you to receive such information.

**RESEARCH:** Under certain limited circumstances, we may use and disclose deidentified medical information about you for research purposes. For example, a research project may involve the care and recovery of all members who have been treated for the same condition. All research projects are subject to a special approval process. The results of our research will also never identify you as an individual.

**APPOINTMENT REMINDERS:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or services.

**HEALTH-RELATED INFORMATION OR RESOURCES:** We may use and disclose medication information to tell you about other available health center resources that may be of use or interest to you.

**SUBSTANCE ABUSE HEALTH INFORMATION**: The confidentiality of records related to the diagnosis, treatment, referral for treatment, or prevention of alcohol or drug abuse is protected by federal law and regulations (42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2). Generally, a substance abuse program may not disclose to anyone outside the program that you attend the program or disclose any information identifying you as an alcohol or drug abuser, unless:

- ♦ You consent in writing, or
- ♦ The disclosure is allowed by a court order, or
- ♦ The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research audit or program evaluation, or
- ♦ You commit or threaten to commit a crime either at the program or against any person who works for the program.

Suspected violations may be reported to the United States Attorney in the district where the violation

occurs, or to the organization's Office of Family and Consumer Affairs. Tribal law requires and federal law permits, a substance abuse program to report suspected child abuse or neglect to appropriate authorities. Violations of the tribal and/or federal law and regulations by a program are a crime.

**HIV INFORMATION:** All health information related to HIV is kept strictly confidential . Disclosure of any health information referencing your HIV status may only be made with your specific written authorization. A general authorization for the release of medical or other information is not sufficient for this purpose.

**RIGHTS OF MINORS:** A person aged 14 or older may consent to behavioral health treatment and authorize disclosure of information as if s/he were an adult. If the treatment is inpatient – the child's custodian must be notified.

## SPECIAL OR UNUSUAL CIRCUMSTANCES

Pursuant to applicable law, Laguna Community Healthcare Center may disclose medical information about you without your written authorization in certain special situations.

**PUBLIC HEALTH RISKS (Health and Safety for you and/or others.):** We may disclose medical information about you for public health activities, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. These activities generally include the following:

- ♦ to prevent or control disease, injury or disability
- ♦ to report births or deaths
- ♦ to report child abuse or neglect
- ♦ to report reactions to medications
- ♦ to notify people of recalls of medications they may be using
- ♦ to notify a person who may have been exposed to a disease or may be at risk for contracting a disease or condition
- ♦ to avert a serious threat to the health or safety of a person or the public
- ♦ to notify the appropriate government authority if we believe a member has been the victim of abuse, neglect or domestic violence. We will make this disclosure when required or authorized by law.

**HEALTH OVERSIGHT ACTIVITIES:** We may disclose medical information about you to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the behavioral health care system, government programs and compliance with civil rights laws.

**LAWSUITS AND DISPUTES:** If you are involved in a lawsuit or legal action, we may disclose medical information about you in response to a valid court or administrative order. We may also disclose medical information about you in response to a valid subpoena, discovery request, or other lawful process by someone else involved in the dispute.

**LAW ENFORCEMENT:** We may release protected health information about you if asked to do so by a law enforcement official:

- ♦ In response to a valid court order, subpoena, warrant, summons, or similar lawful process
- ♦ Provide limited information to identify or locate a suspect, fugitive, material witness, or missing person, under certain circumstances.
- ♦ About the victim of a crime if, under certain limited circumstances,

we are unable to obtain the person's authorization

- ♦ About a death we believe may have been the result of criminal conduct
- ♦ About criminal conduct at LAGUNA COMMUNITY HEALTHCARE CENTER
- ♦ In emergency circumstances to report a crime on LHC premises or as required by law, the location of the crime or victims, or the identity, description or location of the person who committed the crime

**CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS:** We may release medical information to a person, or medical examiner, authorized to receive such information. This may be necessary to identify a deceased person or determine the cause of death. We may also release medical information about you to funeral directors as necessary to carry out their duties.

**AS REQUIRED BY LAW:** We will disclose medical information about you when required to do so by applicable laws.

**EMERGENCY SERVICES:** In the case of an emergency (where we assess there may be danger to self, others or grave disability) we may disclose your medical information to provide you the appropriate services.

**BREACH NOTIFICATION:** If there is a breach of unsecured protected health information (PHI) concerning you, we will notify you of this breach, including what happened and what you can do to protect yourself.

## YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

**RIGHT TO INSPECT AND COPY:** You have the right to inspect and have copies made by Laguna Community Healthcare Center of medical information that may be used to make decisions about your care. Usually, this includes progress notes, evaluations/assessments, treatment plans, and billing information.

To inspect and copy your medical information, contact the Privacy Officer. If you request a copy of the information, you may receive one copy at no cost each year. For any additional copies during the same year, you may be charged a fee for the costs of copying, mailing, or other supplies associated with your request.

Your request to inspect and copy your information may be denied in certain very limited circumstances. In those circumstances, the agency retains the right to withhold information when it may be detrimental to your care. If you are denied access to any part of your medical information, you may request that the denial be reviewed. Information regarding how to initiate that review process will be provided in writing at the time of any denial of your access to the information.

**RIGHT TO AMEND:** If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as your medical information is kept by Laguna Community Healthcare Center.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide a reason that supports your request. We may deny your request if you ask us to amend information that:

- ♦ It was not created by us, unless the person or entity that created the information is no longer available to make an amendment
- ♦ Is not part of the medical information kept by or for Laguna Community Healthcare Center
- ♦ Is it not part of the information which you would be permitted to inspect or copy, or
- ♦ It is accurate and complete

**RIGHT TO AN ACCOUNTING OF DISCLOSURES:** You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you to others. The accounting does not include information disclosed based on your written permission or as a part of treatment, payment or health care operations. To request this accounting, you must submit your request in writing to the Privacy Officer. You have a right to receive an accounting of disclosures to which you have consented for the six (6) years prior to the date on which the accounting is requested and as required by HIPAA. For example, this would include special considerations and emergency disclosure. You have the right to an accounting of disclosures of electronic records related to your SUD diagnosis, treatment or referral for SUD treatment under this part for the three (3) years prior to the date on which the accounting is requested.

**RIGHT TO REQUEST RESTRICTIONS:** You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree with your request for restrictions for treatment, payment, and healthcare operations. If we do agree, we will comply with your request unless you take affirmative steps to revoke it or the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us what information you want to limit, and to whom you want the limit to apply. In rare circumstances, we reserve the right to terminate a restriction that we have previously agreed to, but only after providing you notice of termination

**RIGHT TO REQUEST CONFIDENTIAL INFORMATION:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location if you believe that you will be otherwise endangered. For example, you can ask that we only contact you at a certain telephone number or address. We will accommodate all reasonable requests. Your request must specify in writing how or where you wish to be contacted. You can request confidential communications when you initiate or update your demographic information in the electronic clinical record.

**RIGHT TO PAPER COPY OF THIS NOTICE:** You have the right to a paper copy of this privacy notice. You may ask us to give you a copy of this privacy notice at any time by requesting a copy from the Privacy Officer.

**CHANGES TO THIS NOTICE**

Laguna Community Healthcare Center reserves the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information Laguna Community Healthcare Center already has about you as well as any information we will receive in the future. Laguna Community Healthcare Center will post a copy of the current notice at all locations and on its website. The notice will contain the effective date. Laguna Community Healthcare Center will make you aware of any revisions by posting a revised notice in all the above locations.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may contact or file a complaint with:

Sherry Heath
Compliance Officer
Laguna Community
Healthcare Center
6 Basswood Road
Paraje, NM 87007

For further questions, you may contact the Compliance Officer 505-431-0720. If we cannot resolve your concern, you also have the right to file a written complaint with the LCHC Compliance Officer. We will not retaliate against you for filing a complaint and the quality of your care will not be jeopardized, nor will you be penalized for filing a complaint with us or with the U.S. Department of Health and Human Services.

If you believe your rights have been violated and would like to submit a complaint directly to the U.S.

Department of Health & Human Services, then you may submit a formal written complaint to the following address:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: 877-696-6775
Email: OCRMail@hhs.gov
Website: www.hhs.gov

## OTHER ISSUES

Other uses and disclosures of medical information not covered by this notice or the laws that apply to Laguna Community Healthcare Center will be made only with your written permission. If you provide us with permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered in your written authorization. Laguna Community Healthcare Center is unable to take back any disclosures already made with your permission, and we are required to retain our records of the care and services we provide to you.


# ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
## Laguna Community Health Clinic

Please sign this form and return it to the person who gave it to you. If you received this booklet by mail, you may return this form in the attached envelope.

**My signature on this form indicates that I have received the Notice of Privacy Practices**.

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

_____

Personal Representative's Relationship or Authority

_____ _____

LCHC Employee Signature/Title Date

**Laguna Community Health Center**
**PO BOX 1407, Laguna, NM 87026**
**(505) 431-0711 Fax: (505) 552-9456**
**www.lagunahealthcare.org**

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

**1. Person(s) or Organization to whom disclosure is to be made:**

| | |
|---|---|
| Patient's Name: | Date of Birth: |
| Previous Name: | Last 4 Digits of Social Security #: |
| I request and authorize _____ to release healthcare information of the patient named above to: | Laguna Community Health Center<br>Attention: Medical Records<br>PO BOX 1407<br>Laguna, NM 87026 Fax: (505) 552-9456 |

**2. Specify type of information to be disclosed****

Date: _____ Date Through: Current

| | |
|---|---|
| ☐ Complete Copy (Charges May Apply) | ☐ Pertinent Copy (Dictated reports/diagnostic tests) |
| ☐ Labs | ☐ Operative Reports |
| ☐ Radiology/ X-Ray | ☐ Emergency Reports |
| ☐ Cardiology | ☐ Discharge Summary |
| ☐ Nuclear Medicine | ☐ Other (treatment notes, diagnosis, etc) |

**3. The purpose and need for such disclosure, if requested by a person other than the patient or authorized representative:**

| | |
|---|---|
| ☐ Continuation of Treatment of Health Care | ☐ Insurance Investigation |
| ☐ Vocational Rehabilitation | ☐ Social Service Referral |
| ☐ Disability Determination | ☐ Billing Information |

Other (Specify)_____

**4. Information is to be:**

| | | |
|---|---|---|
| ☐ Mailed | ☐ Electronic Access Employee | ☐ Faxed (Doctor's Office/Hospitals Only |
| ☐ Picked Up | ☐ Electronic Access LCHC record | |

If pick-up is checked, by whom (name): _____

(If someone other than patient will pick-up, include letter of authorization signed by patient or authorized representative.)

5. **Sexually Transmitted Disease (STD) includes but is not limited to herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.**

| | |
|---|---|
| ☐ Yes<br>☐ No | I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. |

Patient Signature: _____ Date: _____

6. **Specify type of Substance Use Patient Records to be disclosed:**

   **_____I authorize the release of information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2.**

   **_____I authorize release of information to include psychiatric/psychological services records, and, if any, social work records that include communication by me to a social worker or psychiatrist/psychologist.**

Patient Signature: _____ Date: _____

7. **I understand this authorization is voluntary and is subject to written revocation at any time by notifying the individual(s) or organization releasing this information in writing, except to the extent that Laguna Community Health Center (LCHC) has already taken action in reliance on the authorization. This authorization will expire 90 days after it is signed, upon disclosure of requested information or on (Insert date) _____.**

   **I understand the LCHC will not condition treatment or eligibility for care on my providing this authorization, except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information (PHI) for disclosure to a third party.**

   **I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].**

**Patient Signature:** _____ Date: _____

**Authorized Representative:** _____ Date: _____

**Relationship to Patient:** _____

** LCHC reserves the right to charge for processing and copying information. This fee is waived when releasing pertinent information directly to a treating physician or health care facility.

# LCHC NEW PATIENT MEDICAL HISTORY FORM

Full Name:_____ Date:_____

Birth Date:_____ Age: _____

## ALLERGIES

o **NO ALLERGIES**

| ALLERGY | ALLERGIC REACTION |
|---|---|
| | |
| | |
| | |
| | |

## MEDICATIONS

| MEDICATIONS *(Please list ALL)* | DOSE *(Mg., pill, etc.)* | TIMES PER DAY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*If you need more room to list medications, please write them on the back of the last page with the required information*

## HEALTH MAINTENANCE SCREENING TEST HISTORY

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **COLONOSCOPY/SIGMOID** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **MAMMOGRAM** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **PAP SMEAR** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **BONE DENSITY** | Date: | Facility/Provider: | Abnormal Result? Y N |

## VACCINATION HISTORY

| | |
|---|---|
| Last Tetanus Booster or TdaP: | Last Pnuemovax *(Pneumonia)*: |
| Last Flu Vaccine: | Last Prevnar: |
| Last Zoster Vaccine *(Shingles)*: | COVID: 1ST _____ 2ND _____ Brand_____ |

## PERSONAL MEDICAL HISTORY

| DISEASE/CONDITION | CURRENT | PAST | COMMENTS |
|---|---|---|---|
| Alcoholism/Drug Abuse | | | |
| Asthma | | | |
| Cancer *(type:_____)* | | | |
| Depression/Anxiety/Bipolar/Suicidal | | | |
| Diabetes *(type:_____)* | | | |
| Emphysema *(COPD)* | | | |
| Heart Disease | | | |
| High Blood Pressure *(hypertension)* | | | |
| High Cholesterol | | | |
| Hypothyroidism/Thyroid Disease | | | |
| Renal *(kidney)* Disease | | | |
| Migraine Headaches | | | |
| Stroke | | | |
| Other: | | | |
| Other: | | | |

## SURGERIES

| **TYPE** *(specify left/right)* | DATE | LOCATION/FACILITY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## WOMEN'S HEALTH HISTORY

| | |
|---|---|
| Date of Last Menstrual Cycle: | Age of First Menstruation:____Age of Menopause: _____ |
| Total Number of Pregnancies: | Number of Live Births: |
| Pregnancy Complications: | |

## FAMILY MEDICAL HISTORY

o **No Significant Family History Known**

| CHECK ALL THAT APPLY | Alcohol/Drug | Asthma | Cancer (type: ) | Emphysema | Depression/Anxiety | Bipolar/Suicidal | Diabetes | Early Death | Heart Disease | High Cholesterol | High Blood | Kidney Disease | Stroke | Thyroid Disease | Migraines | Other:_____ | Other:_____ | Other:_____ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | | | | | | |
| Child | | | | | | | | | | | | | | | | | | |
| MGM | | | | | | | | | | | | | | | | | | |
| MGF | | | | | | | | | | | | | | | | | | |
| PGM | | | | | | | | | | | | | | | | | | |
| PGF | | | | | | | | | | | | | | | | | | |
| Other:_____ | | | | | | | | | | | | | | | | | | |

## SOCIAL HISTORY

| | |
|---|---|
| Occupation *(or prior occupation)*: | o Retired o Unemployed o LOA o Disabled |
| Employer: | Years of Education or Highest Degree: |
| If employed, do you work the night shift? Y N N/A | |
| Marital Status *(check one)*: o Single o Partner o Married o Divorced o Widowed o Other:_____ | |
| Do you have children? Y N | If yes, how many? |

## OTHER HEALTH ISSUES

| | | | |
|---|---|---|---|
| **TOBACCO USE** | Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)* | | |
| ***Current:*** Packs/day____# of Years _____ | ***Past:*** Quit Date:_____Packs/day_____# of Years _____ | | |
| Other Tobacco *(check one)*: o Pipe o Cigar o Snuff o Chew | | | |
| **ALCOHOL/DRUG USE** | Do you drink alcohol? Y N | o Beer o Wine o Liquor | # of Drinks/week: |
| Do you use marijuana or recreational drugs? Y N | | Have you ever used needles to inject drugs? Y N | |
| Have you ever taken someone else's drugs? Y N | | | |

Patient Name: _____ DOB: _____

## OTHER HEALTH ISSUES continued...

| | | |
|---|---|---|
| **SEXUAL ACTIVITY** | Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)* | |
| Sexual partner(s) is/are/have been: o Male o Female | | |
| Birth control method: o **None** o **Condom** o **Pill/Ring/Patch/Inj/IUD** o **Vasectomy** | | |
| **EXERCISE** | Do you exercise regularly? Y N *(If you answered no, please move to Sleep)* | |
| What kind of exercise? | ***Duration:*** How long (min.):_____How often: _____ | |
| **SLEEP** | How many hours, on average, do you sleep at night *(or during the day, if working night shift)*? | |
| **DIET** | How would you rate your diet? o Good o Fair o Poor | Would you like advice on your diet? Y N |
| **SAFETY** | Do you use a bike helmet? Y N | Do you use seat belts consistently? Y N |
| Working smoke detector in home? Y N | | If you have guns at home, are they locked up? Y N |
| Is violence at home a concern for you? Y N | | Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N |

## OTHER PROVIDERS/SPECIALISTS

| SPECIALIST | NAME | LAST VISIT |
|---|---|---|
| Cardiology | | |
| Gastroenterologist (GI) | | |
| OB/GYN | | |
| Neurology | | |
| Pulmonary | | |
| Other:_____ | | |
| Other:_____ | | |

## ADDITIONAL INFORMATION

| | |
|---|---|
| Have you traveled outside of the country in the last 30 days? Y N | If yes, where? |
| Have you served in the military? Y N | If yes, how long and what branch? |
| Were you deployed? Y N | If yes, where? |

Patient Name: _____ DOB: _____

## REVIEW OF SYSTEMS CHECK ALL THAT APPLY

| CONSTITUTION | CARDIOVASCULAR | SKIN |
|---|---|---|
| ☐ Activity change | ☐ Chest pain | ☐ Color change |
| ☐ Appetite change | ☐ Leg swelling | ☐ Pallor |
| ☐ Chills | ☐ Palpitations | ☐ Rash |
| ☐ Diaphoresis | **Gastrointestinal** | ☐ Wound |
| ☐ Fatigue | ☐ Abdominal distention | **ALLERGY/IMMUNO** |
| ☐ Fever | ☐ Abdominal pain | ☐ Environmental allergies |
| ☐ Unexpected weight change | ☐ Anal bleeding | ☐ Food allergies |
| **Head, Ear, Nose & Throat** | ☐ Blood in stool | ☐ Immunocompromised |
| ☐ Congestion | ☐ Constipation | **NEUROLOGICAL** |
| ☐ Dental problem | ☐ Diarrhea | ☐ Dizziness |
| ☐ Drooling | ☐ Nausea | ☐ Facial asymmetry |
| ☐ Ear discharge | ☐ Rectal pain | ☐ Headaches |
| ☐ Ear pain | ☐ Vomiting | ☐ Light-headedness |
| ☐ Facial swelling | **ENDOCRINE** | ☐ Numbness |
| ☐ Hearing loss | ☐ Cold intolerance | ☐ Seizures |
| ☐ Mouth sores | ☐ Heat intolerance | ☐ Speech difficulty |
| ☐ Nosebleeds | ☐ Polydipsia | ☐ Syncope |
| ☐ Postnasal drip | ☐ Polyphagia | ☐ Tremors |
| ☐ Rhinorrhea | ☐ Polyuria | ☐ Weakness |
| ☐ Sinus pressure | **GENITOURINARY** | **HEMATOLOGIC** |
| ☐ Sneezing | ☐ Difficulty urinating | ☐ Adenopathy |
| ☐ Sore throat | ☐ Dysuria | ☐ Bruises/bleeds easily |
| ☐ Tinnitus | ☐ Enuresis | **PSYCHIATRIC** |
| ☐ Trouble swallowing | ☐ Flank pain | ☐ Agitation |
| ☐ Voice change | ☐ Frequency | ☐ Behavior problem |
| **EYES** | ☐ Genital sore | ☐ Confusion |
| ☐ Eye discharge | ☐ Hematuria | ☐ Decreased concentration |
| ☐ Eye itching | ☐ Penile discharge | ☐ Dysphoric mood |
| ☐ Eye pain | ☐ Penile pain | ☐ Hallucinations |
| ☐ Eye redness | ☐ Penile swelling | ☐ Hyperactive |
| ☐ Photophobia | ☐ Scrotal swelling | ☐ Nervous/anxious |
| ☐ Visual disturbance | ☐ Testicular pain | ☐ Self-injury |
| **RESPIRATORY** | ☐ Urgency | ☐ Sleep disturbance |
| ☐ Apnea | ☐ Urine decreased | ☐ Suicidal ideas |
| ☐ Chest tightness | **MUSCULAR** | |
| ☐ Choking | ☐ Arthralgias | |
| ☐ Cough | ☐ Back pain | |
| ☐ Shortness of breath | ☐ Gait problems | |
| ☐ Stridor | ☐ Joint swelling | |
| ☐ Wheezing | ☐ Myalgias | |
| ☐ | ☐ Neck pain | |
| ☐ | ☐ Neck stiffness | |

Patient Name: _____ DOB: _____

**Continue medication list on this page**

Add any other notes here.

# Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Your Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**Your Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Notification to family whether you are currently present in the facility
- Provide mental health care
- Market our services

**Our Uses and Disclosures**

We may use and share your information as we:

- Treat you
- Organization Operations
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting the LHC Compliance Officer.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visit **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

**<u>Your Choices</u>**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Authorize notification to family as to whether you are currently in the facility

  *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes

## Our Uses and Disclosures

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Organization Operations**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual passes.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

**Changes to the Terms of this Notice**
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: March 1, 2021

Privacy Officer: Sherry Heath, Compliance Officer

PO Box 1407, Laguna, NM 87026

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