PATIENT INFORMATION: Please Print

Patient Name: (Last, First): ______________________________________Date of Birth:___________________

Social Security Number: ________________________ Gender: (M / F) Marital Status: (S / M / D / W)

Address:______________________________________City:________________State:_______Zip:__________

Home Phone: ____________________Work Phone: ___________________Other Phone:_________________

Employed (circle one): Full Time Part Time Seasonal Unemployed Disabled Retired

Employer:____Phone:___________________________

Race (circle one): Asian/Pacific Islander African-American White East Indian Hispanic/Latino Native American Combined Race Other

Preferred Language:_______________________________________ Translator Needed? YES / NO

Housing (circle one): Own Rent Public Assisted Friend Migrant Homeless Other

Is patient a student? YES / NO School:____________________ Full Time/Part Time Years Completed___

<u>EMERGENCY CONTACT INFORMATION:</u>

Name of person to contact in case of emergency: ____________________________Relationship:___________

Phone Number (1)_____________________________________(2)______________________________________

PROTECTED HEALTH INFORMATION:

I hereby authorize release of my Protected Health Information for discussion of my care and treatment and/or payment to the person(s) specified below. This does not give the listed person(s) permission to make health care decisions for the patient. Jordan Valley Community Health Center (JVCHC) will not release via the telephone or any other means of communication any information to any friend or family member not listed with the exception when it is reasonable to assume that the patient does not object such as when a patient brings and individual into the exam room when treatment is discussed. (45CFR. 164.502(F) & 164.502(G).

1. ____

Name **Relationship** **Phone**

2. ____

Name **Relationship** **Phone**

3. ____

Name **Relationship** **Phone**

Billing Policy & Insurance Information:

Guarantor Information (To whom the billing statement should be sent)
Name (Last, First): ________________________________Social Security Number (Guarantor): ___________
Address: ____City/State/Zip: ______________________________
Home Phone: _____________________ Work Phone: _____________________ Other Phone: _____________

Time of Service Payment: It is the policy of JVCHC to collect payment at the time of service. This includes all co-pay amounts, deductibles, private individuals, and sliding fee co-pay.
Insurance Billing Agreement: As a courtesy, JVCHC will file your insurance claim. However, the responsibility for the prompt payment of your carrier remains with you. It is not our policy to contact out-of-network carriers to establish what they have paid or why they have paid less than originally indicated since we are not a party to your agreements with your insurance carrier or employer. However, we try to cooperate to the fullest in supplying your carrier with all information needed. The form for insurance processing will be mailed to you if an address or other required information is needed is not available.
Workers Compensation Claims: I understand that if I state my need to medical care is the result of a work related injury; my claim will be sent to my employer for processing by their compensation carrier. It will be my responsibility to pay any portion of this claim that is denied or determined not to be related or if I fail to provide adequate information to file this claim.
Liability/Motor Vehicle Accident Claims: We do not file liability insurance, such as motor vehicle or third-party coverage. We will be glad to give you whatever information you need so you can file your own claims for third-party coverage.
Financial Agreement: I agree to pay JVCHC for services rendered to me. I acknowledge that payment is due at time of service and payable upon receipt of a monthly billing statement. **Failure to pay will result in no further appointments until the account has been paid in full.** If payment has not been received within 120 days from the date of service, it will be sent to collections. Payment agreements may be made with our billing department if accounts cannot be paid in full at the time of service.

Primary Insurance Company: ____ Policy Number: _________________

Secondary Insurance Company: ____ Policy Number: _________________

I request that payment of authorized Medicare or other insurance company benefits be made either to me or on my behalf to the physician(s) of JVCHC for any services provided to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare or other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand billing information relating to services I receive could be released to my insurance provider for payment of services received.
Confidentiality: I am aware that information about my treatment is considered confidential and will be used in a manner consistent with proper professional conduct and will only be released to outside sources under applicable state and federal law statutes and regulations or when ordered by a court of competent jurisdiction.
I understand it is my responsibility to call the 24 hour crisis hot line at 1-800-494-7355 or 417-862-6555 should I consider harming myself or others. I understand that this crisis line is staffed by Burrell Behavioral Health employees under contract of the JVCHC to provide crisis assistance.

Consent for Treatment-ADULT: By signing below I am giving consent to receive any treatment or procedure deemed necessary by the professional staff of JVCHC. I understand all the preceding statements and will adhere to the stated policies.

Consent for Treatment-CHILD or INCAPACITATED ADULT: By signing below I hereby state that I am the parent, primary legal custodian, or joint legal custodian of the patient being presented today for treatment. By signing below I am giving consent as guardian for any treatment or procedure deemed necessary by the professional staff of JVCHC. I understand all the preceding statements and will adhere to the stated policies.

I have had the opportunity to receive a copy of Jordan Valley Community Health Center's Notice of Privacy Practices.

Print Name of Patient: ____ Date: _____________________

Patient/Legal Guardian Signature: ____ Date: _____________________

Community Health Center
P. O. Box 5681
Springfield, MO 65801-5681
www.jvchc.com

Thank you for your interest in Jordan Valley Community Health Center. JVCHC gladly accepts Medicaid, Medicare, and private insurance. As a Federally Qualified Heath Center, we offer a discounted rate (slide program) to those who do not have medical or dental coverage and whose household income meets the income quideline. The patient must complete the application process in order to determine eligibility. The slide program enrollment can be done at the time of your first appointment, if all the proper paperwork is in order.

MEDICAL SERVICES

Qualifying individuals receive medical office visits at the discounted rate of $30.00 per visit. All payments are due at the time of service rendered. Checks, cash and credit cards are accepted.

DENTAL SERVICES

JVCH dental clinic provides services at a discounted rate to those who qualify. The dentist will determine a plan of treatment and will discuss with the patient the cost of services to be provided. Payment is due at the time of services rendered. Checks, cash, and credit cards are accepted.

OTHER SERVICES

In addition, JVCHC provides discounted prescriptions to our patients through our in-house pharmacy located at the Karney facility.

Individuals who would like to apply for Medicaid may complete the application process at JVCHC by calling (417) 831-0150 and asking for Susan Rapp, our on-site Medicaid caseworker.

JVCHC looks forward to assisting you.

June 2008

Jordan Valley Community Health Center - HEALTH HISTORY (Part I)

Name: ______________________________________**Today's Date:** ________________________
Date of Birth: _____________

Medical History (Check all that apply)

- ◻ General good health
- ◻ ADHD
- ◻ Alcoholism
- ◻ Allergic Rhinitis
- ◻ Anemia
- ◻ Anxiety
- ◻ Arthritis
  (Type ___________________)
- ◻ Asthma
- ◻ Atrial Fibrillation
  (rapid heart rate)
- ◻ Cancer
  (Type ___________________)
- ◻ Chronic Bronchitis
- ◻ Chronic Back Pain
- ◻ Congestive Heart Failure
- ◻ COPD/ Emphysema
- ◻ Dementia
- ◻ Depression
- ◻ Diabetes
  (Date of diagnosis ________)
- ◻ Epilepsy
- ◻ Glaucoma
- ◻ Heart disease
  (History of heart attack ___)
- ◻ Heartburn/Acid Reflux
- ◻ Herpes
- ◻ High blood pressure
- ◻ High Cholesterol
- ◻ HIV disease
- ◻ Hyperthyroidism
- ◻ Hypothyroidism
- ◻ Kidney Disease
- ◻ Liver Disease/ Hepatitis
  (Type ___________________)
- ◻ Migraine Headache
- ◻ Pacemaker
- ◻ Parkinson's disease
- ◻ Premature Birth
- ◻ Prostate Disorder
- ◻ STD
  (Type __________________)
- ◻ Stroke
- ◻ Sleep Apnea
- ◻ Suicide Attempt
- ◻ Other ____________________
  ____
  ____

Hospitalizations (not including childbirth)

Year/Date of Hospitalization	Reason for Hospitalization

Surgical History (Check all that apply)

- ◻ Appendectomy (Appendix removed)
- ◻ Cholecystectomy (Gallbladder removed)
- ◻ Tonsillectomy (Tonsils removed)
- ◻ Hysterectomy (Uterus removed)
  Removed for cancer Yes No
  Year Removed _________________________
- ◻ Oopherectomy (Ovaries removed)
  Removed for cancer Yes No
- ◻ Other ________________________________
  ____
  ____

Other physicians/specialists you currently see: ____

Previous primary care physician: ________________________________ Last seen: ____________________________

Dentist's name: ____ Last seen: _____________________________________

Drug Allergies (describe the reaction)

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

Family History

Include only MGM (maternal grandmother), MGF (mat. grandfather), PGM (pat. grandmother), PGF (pat. grandfather), Mother, Father, Brother, Sister, Aunt, Uncle, Son, Daughter

	Yes	No	Who
Heart Disease	__	___	________________________________
High Cholesterol	__	___	________________________________
Stroke	__	___	________________________________
High Blood Pressure	__	___	________________________________
Diabetes	__	___	________________________________
Seizure disorder	__	___	________________________________
Thyroid Disease	__	___	________________________________
Asthma	__	___	________________________________
Anemia	__	___	________________________________
Bleeding Disorder	__	___	________________________________
Osteoporosis	__	___	________________________________
Osteoarthritis	__	___	________________________________
Rheumatoid Arthritis	__	___	________________________________
Depression	__	___	________________________________
Bipolar disorder	__	___	________________________________
Schizophrenia	__	___	________________________________
Alcoholism	__	___	________________________________
Breast Cancer	__	___	________________________________
Uterine Cancer	__	___	________________________________
Ovarian Cancer	__	___	________________________________
Prostate Cancer	__	___	________________________________
Colon Cancer	__	___	________________________________
Other	__	___	________________________________

Mother still living? Yes/No Current Age: ______ Age at Death _______ Cause of Death ______________________

Father still living? Yes/No Current Age: ______ Age at Death _______ Cause of Death ______________________

Jordan Valley Community Health Center - HEALTH HISTORY (Part II)

Social History (Circle all that apply)

Marital Status Single Married Divorced Widowed Other: ______________________

Exercise None Yes Intensity level (mild moderate heavy) Type: ______________

How Often per week _____________

Nutrition Healthy Poor Vegetarian Low Fat Other: ______________________

Caffeine None Coffee/Tea/Soda 1-2/day 3-4/day +5/day Other: ________

Alcohol None Rare Social Weekly Daily Other: ________

Illicit Drugs (including marijuana) Never Previously Date of Last usage _________________________

Type (list all) ____

Tobacco Never Previously Currently Other:

Type and Amount per day ____________________ How many Years? ____________

Seat belt Always Sometimes Never

Education Elementary High school College Masters Doctorate Technical/Trade

Employment Part time Full time Student Disability Unemployed Retired

Profession/Place of Employment: ____

If disabled, reason and date of disability: ____

Sunscreen usage Yes No

Hobbies ____

Religious Preference ______________________________

 # in Household __________________________________

Significant other's name ______________ __□ Spouse

Children's names ________________________________

____

Preventive History (Most recent testing with results)

Colonoscopy Date______ Results ___________

Bone density Date______ Results ___________

Cholesterol Date______ Results ___________

Dental Visit Date______ Results ___________

Eye Exam Date _____

Tetanus booster __________ Date ____________

Pneumonia vaccine Date ____________

Daily Calcium/Vitamin D intake Y / N

Female History

Number of Pregnancies ________

Live births ____________

Miscarriages __________

Terminations__________

Age starting periods __________

Age of Menopause ___________

Birth control method Y / N

Type: ________________

Abnormal Pap Smear Y / N

Date: ________________

Last Mammogram

Date: ________________

Normal Y / N

NAME: ____________________________ **DATE OF BIRTH:** ________________________ **TODAYS DATE:** _

PLEASE MARK ALL SYMPTOMS THAT ARE BOTHERING YOU TODAY

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ Poor appetite
- ☐ Malaise (weakness)
- ☐ Fatigue

EYES
- ☐ Visual change
- ☐ Blurred vision
- ☐ Redness
- ☐ Pain
- ☐ Tearing
- ☐ Itching
- ☐ Drainage

EARS/NOSE/THROAT
- ☐ Sinus Pressure
- ☐ Congestion
- ☐ Rhinorrhea (runny nose)
- ☐ Drainage
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Ear pain
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Dental pain

HEART
- ☐ Chest pains
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Cannot sleep laying flat
- ☐ Wake up gasping for air
- ☐ Swelling in legs
- ☐ Leg pain with walking
- ☐ Feeling fainting
- ☐ Passing out

LUNGS
- ☐ Cough
- ☐ Sputum production
- ☐ Change in sputum
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ TB exposure

ABDOMEN
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pains
- ☐ Heartburn/reflux
- ☐ Change in appetite
- ☐ Vomiting blood
- ☐ Bloody or black stools
- ☐ Change in bowel pattern

FEMALE GENITOURINARY
- ☐ Burning with urination
- ☐ Frequency
- ☐ Leaking urine (incontinence)
- ☐ Breastfeeding
- ☐ Breast lumps
- ☐ Vaginal discharge or itching
- ☐ Risk of sexually transmitted disease
- ☐ Pain with intercourse
- ☐ Pain with menses
- ☐ Irregular menses
- ☐ Heavy menses

MALE GENITOURINARY
- ☐ Frequency
- ☐ Trouble starting urine stream
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Leaking urine (incontinence)
- ☐ Discharge from penis
- ☐ Risk of sexually transmitted disease
- ☐ Trouble with erections
- ☐ Testicular lump
- ☐ Testicular pain
- ☐ Bloody ejaculate

MUSCLES/JOINTS
- ☐ Muscle aches
- ☐ Joint aches
- ☐ Weakness
- ☐ Joint stiffness
- ☐ Swollen or hot joints
- ☐ Muscle cramps
- ☐ Back pain
- ☐ Pain radiating down leg
- ☐ Trigger points
- ☐ Trouble with function

SKIN
- ☐ Rash
- ☐ Lesions
- ☐ New lesions
- ☐ New or changing moles
- ☐ Wounds
- ☐ Itching
- ☐ Change in nails

NEUROLOGIC
- ☐ Confusion
- ☐ Dizziness - room spinning
- ☐ Memory problems
- ☐ Tingling sensation
- ☐ Weakness
- ☐ Inability to move
- ☐ Seizures
- ☐ Headaches
- ☐ Tremors
- ☐ Bladder incontinence
- ☐ Bowel incontinence

PSYCHOLOGIC
- ☐ Depressed mood
- ☐ Anxious mood
- ☐ Emotional
- ☐ Irritable and angry
- ☐ Increased stress
- ☐ Poor attention
- ☐ Difficulty sleeping
- ☐ Fears
- ☐ Seeing things or hearing voices
- ☐ Thoughts of hurting self
- ☐ Thoughts of hurting others

ENDOCRINE
- ☐ Trouble staying warm or cold
- ☐ Change in skin texture
- ☐ Change in hair texture
- ☐ Weight gain
- ☐ Weight loss
- ☐ Increase thirst
- ☐ Increase appetite
- ☐ Increase urination

OTHER
- ☐ Abnormal bleeding
- ☐ Abnormal bruising
- ☐ Enlarged lymph nodes
- ☐ HIV exposure
- ☐ Persistent infections
- ☐ Seasonal allergies
- ☐ Hives

CHILDREN

Is your child having any of the following symptoms?
- ☐ Fever
- ☐ Congestion
- ☐ Cough
- ☐ Pulling at ears
- ☐ Teething
- ☐ Fussiness
- ☐ Drinking less than normal
- ☐ Eating less than normal
- ☐ Urinating less than normal
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation

Is there anything else that you would like for us to know?

____
____
____
____
____

Chronic Pain Management Policy

1. Chronic pain is an unfortunate, but very common problem. There is no simple medical answer for those with chronic pain. The goal of treatment is to help the individual manage the pain rather than to eliminate it. No single treatment can cure chronic pain and the best results are obtained with a combination of behavioral health, physical, and occasionally medical treatments. Medications beyond simple over the counter pain remedies are rarely useful unless used along with ongoing behavioral health care and non-medication therapies such as physical therapy. The risk of side effects, addiction, and abuse of opioid (narcotic) pain relievers is substantial. Current national guidelines tell us that there is only a very limited role for chronic opioid therapy in primary care practice. As a result, Jordan Valley is aligning our policies to these guidelines.
2. New patients who have been prescribed chronic opioids elsewhere will not necessarily be continued on them at Jordan Valley. All new patients will provide their prior medical records in a timely fashion. Controlled medications such as narcotics, benzodiazepines, stimulants, etc. will not be prescribed until the prior medical records are available for review and deemed beneficial to continue. Prior use of controlled medications does not constitute automatic continuance of the medication if medical records fail to show significant reasons for the use of the controlled substance.
3. Existing patients on opioid therapy will be reevaluated at their next office visit for appropriateness of continuing therapy. In keeping with national guidelines, it is anticipated that many patients will be removed form opioid therapy. For those who remain on therapy, dosage reduction and efforts to manage pain without opioids will be ongoing effort. To assist patients who are stopping opioid therapy, the provider may prescribe a short course of non-opioid medication to minimize withdrawal symptoms.
4. Jordan Valley will continue to use a combination of therapy to help manage chronic pain. Pain relievers will be used in a very limited fashion and only when deemed beneficial and appropriated by the treating physician. Therapy for chronic pain will include:
    a) Medical evaluation and diagnosis to determine the cause of pain.
    b) Behavioral health evaluation, diagnosis, and care for related disorders.
    c) Non opioid medications commonly used with chronic pain will be considered first.
    d) Referral to specialty care when appropriate, including referral to local pain management centers.
    e) Ongoing care of other medical conditions and preventative health. This is a vital component for all individuals with chronic pain in order to help maintain their health at the highest level possible.
    f) Social services to assist with referrals regarding occupational rehabilitation, accessing services as Medicaid, and when appropriate disability counseling.
    g) Patients will be required to sign a pain management/controlled medication agreement if they are prescribed controlled medication on a regular basis.

I have read and understand the Jordan Valley Chronic Pain Management Policy.

Patient Name ______________________________________ Date ____________

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosers of your information; however, Jordan Valley Community Health Center is not required to agree to a requested restriction.
- Obtain a paper copy of the notice of privacy practices upon request.
- Inspect and obtain a copy of your record, upon written request.
- Amend your health record within the bounds of accuracy as understood by those involved with your care.
- Request communications of your health information by alternative means or at alternative locations, if we are able to do so.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Receive an accounting of disclosures made of your health information.

Complaints

You may complain to Jordan Valley Community Health Center and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Contact Information

If you have questions, or wish to file a complaint, please contact:

Melissa Mooney, Privacy Officer
417-831-0150 ext. 115

If you believe your privacy rights have been violated you may file:

- A complaint with the facility at the above number, or with the secretary of the Department of Health and Human Services at 877-696-6775, or write to them at 200 Independence Avenue SW, Washington, DC 20221.
- A grievance with the Office of Civil Rights by calling 866-627-7748, or 886-788-4989.

We will not use or disclose your health information without your authorization, except as otherwise described in this Notice of Privacy Practices

Effective September 29, 2004

Notice of
Jordan Valley Community Health Center

NOTICE OF PRIVACY PRACTICES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

This notice describes how medical information about you may or may not be used and disclosed and also how you may obtain access to this information. Please review it carefully.

Jordan Valley Community Health Center is required to:

- Maintain the privacy of protected health information.
- Provide you with this notice of its legal duties and privacy practices with respect to you health information.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requestd restriction on how your information is used or disclosed.
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Jordan Valley Community Health Center reserves the right to change its information practices an to make the new provisions effective for all protected health information it maintains. The most recent version of our Privacy Notice will be posted in our facilities, and copies will be made available for you as requested.

Jordan Valley Community Health Center uses your health information for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Jordan Valley Community Health Center.

How Jordan Valley Community Health Center May use or Disclose Your Health Information

For Treatment. Jordan Valley Community Health Center may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider will be documented in your record. During the course of treatment, the provider determines a need to consult with another specialist and obtain input.

Payment. We submit a request for payment to your health insurance company. The health insurance company may request information from us regarding medical care given. We will provide information to them about input.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your ehealth information mayu be disclosed to members of our risk or quality assurance staff, and others to:

- Evaluate the performance of our staff.
- Access the quality of care and outcomes in your cases and similar cases.
- Learn how to improve our facilities and services.
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. Jordan Valley Community Health Center uses your information to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Additional Disclosures Required by Law. Jordan Valley Community Health Center may use and disclose information about you when required by law. For example, Jordan Valley Community Health Center may disclose information for the following purposes:

- To assist law enforcement officials in their law enforcement duties.
- For national security and intelligence activities for the protection of the President.
- To report information related to victims of abuse, neglect, or domestic violence.
- For judicial and legal proceedings pursuant to legal authority.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prvent or control disease, injury, or disability, or for other health oversight activities.

Research. Jordan Valley Community Health Center may use your health information for research purposes, but only after a clinical review board or privacy board has reviewed the research proposal, has established protocols to ensure the privacy of your health information and has approved the research.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to any Workers' Compensation claim you may file.

Oversight Activities: Information may be disclosed for the purpose of oversight activities, such as audits, investigations, licensure, or disciplinary actions or legal proceedings.

Decedents. Health information may be disclosed to coroners to enable them to carry out their lawful duties.

Military. Information will be release when required by military command authorities if you are a member of the armed forces or to appropriate foreign military authorities if you a foreign military personnel.

Inmates: In the case of a prison inmate, information can be released to the correctional facility in which he or she resieds for the following purposes:

- For the institution to provide the inmate with health care
- To protect the health and the safety of the inmate or the health and safety of others.
- For the safety and sercurity of the correctional facility.

Other uses. Other uses and disclosures will be made <u>ONLY</u> with your written authorization regarding future action.