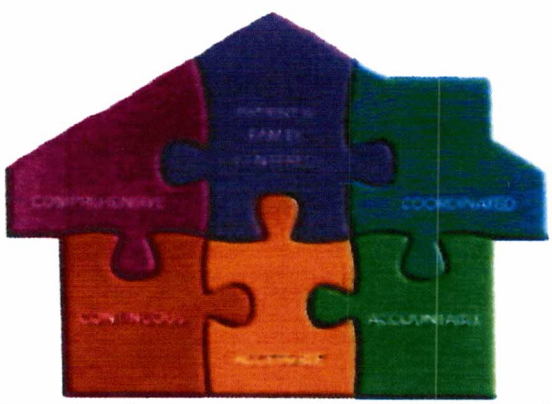
Waterfall Community Health Center

We at Waterfall Community Health Center wish to take a moment to **Welcome** you to your new Medical Home. We want you to know that we appreciate the opportunity we are given to take care of you and your family. Thank you for choosing us as your patient centered home and we look forward to serving you. As your new medical home we will strive to provide you with ease of access to care. You can expect a high standard of care. Your health and wellbeing is our number one concern. Your health goals are our goals!

Waterfall Community Health Center (WCHC) is a nonprofit, community-based, and directed health care center offering the community residents comprehensive health care and outreach services.

WCHC has an extensive array of services such as comprehensive Medical, Behavioral Health, Dental Hygiene and Outreach Services.

We understand that no two patients are the same and that is why your care plan will be designed especially for you. In our medical home model of care, **YOU** are the center of everything we do!



*Please note that controlled substances (stimulants, benzos, hydrocodone, oxycodone, etc) will not be prescribed at your first appointment. All medications are prescribed at the discretion of your Primary Care Provider

Waterfall
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We care about your pain and we want to evaluate and treat it appropriately, with your help. This means:

- The safety of our patients and the community is important to us.
- We have many ways to help with painful conditions. Much of our help will NOT involve prescription medications.
- **"Opiate" pain medicines (sometimes called "narcotics")** Like Vicodin, Oxycodone, Morphine, Tramadol, and Methadone **can cause much harm**.
- **Use of these opiate pain medications is especially dangerous** when combined with other sedatives such as Alcohol, Promethazine, and Benzodiazepines (e.g. Xanax, Klonopin).
- **Other community clinics** in the area **follow the same basic policies.**

Our **clinicians, not management personnel, have final decision-making authority** and responsibility on all prescriptions they write. Generally, they **will not** write a prescription for opiate pain medication:

- At your first visit,
- Without records from your prior clinician's office,
- If pain medication was stopped by another primary care clinician,
- If you are taking Xanax, Valium, Ativan, Klonopin, or are seen at a Methadone clinic,
- If your clinician thinks the potential harms outweigh the potential benefits, especially improvement in function,
- If you have a history of "diversion" (passing your opiates on to another person),
- If you are at high risk for misusing medications (by use of standard tool),
- If you have unstable mental health,
- If you have active substance use or abuse,
- Use of medical marijuana

If you are prescribed opiates for chronic pain:

- We will require ongoing behavioral health services
- Non-medication therapies must be used (e.g. physical therapy, exercise, yoga, chiropractor, acupuncture, relaxation techniques),
- Long-acting pain medication will be preferred,
- Random drug tests, and pill counts will be required,
- The state prescription report will be checked,

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Please fill out all the questions on the Patient Registration Form and Health History Form. If you do not have insurance or have insurance and want a discounted co-pay, please fill out the Sliding Fee Scale Form and provide proof for the last 30 days of income for the entire household. For us to obtain copies of your medical records from your previous provider please fill out the Release of Information form. If there is more than one you can request another form from the Front Office. All other forms that are included in the packet are for your information only.

Thank you for choosing waterfall for your healthcare needs. If you need assistance in filling out these forms please feel free to contact the Patient Access Representative, Alyson Simpson, @ 541-756-6232 to set up an appointment.

Mission "To promote access to quality integrated health services that meet the needs of individuals with barriers to care on the Southern Oregon Coast.

Patient Registration

Waterfall Community Health Center is a Federally Qualified Health Center and receives federal funding pursuant to Section 330 of the Public Health Service Act. We are required to collect information about age, gender, race, sexual orientation, income, and family size for statistical purposes only. No individual information is submitted.

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PATIENT INFORMATION

First Name: | **Middle:** | **Last Name:**

Preferred Name (if different) | **Social Security No (SSN):**

Birthdate: / / MO/DAY/YR

Birth Sex: ☐ Female ☐ Male

I identify as (gender identity): ☐ Male ☐ Female ☐ Other ☐ Transgender Male: Female-to-Male ☐ Transgender Female: Male-to-Female ☐ Choose Not to Disclose

Mailing Address:

City: | **State:** | **Zip:**

Sexual Orientation: ☐ Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose

Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated

Email: ☐ I do not have email

Home Phone: ( ) -

Cell Phone: ( ) -

Work Phone: ( ) -

Household Income: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually

Family Size (include self):

Reduced Fees: Are you interested in applying for our reduced fees (even if you are insured)? ☐ Yes (proof of income will be requested) ☐ No Verified___

Race (choose all that apply): ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ Other ☐ Choose Not to Disclose

Ethnicity (choose one): ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Choose Not to Disclose

Preferred Language: ☐ English ☐ Spanish ☐ Other (specify):

Living Status: ☐ Own Home/Rent ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Unknown ☐ Other: _____ ☐ Public Housing

Employment Status: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Retired

Employer (if applicable): ☐ US Citizen

Farmworkers:
Does anyone in your household work in the fields or food processing plants? ☐ Yes ☐ No ☐ Seasonal
If yes, did he/she work in the fields or food processing plants away from this area in the past 24 months? ☐ Yes ☐ No

Veteran's Status: ☐ Veteran ☐ Non-Veteran

RESPONSIBLE PARTY

Primary Responsible Party (Legal and/or Financial)

First Name: | **Middle:** | **Last Name:** | **Birthdate:** / / | **Address** (if different): | **Phone:**

Employer: | **Employer Phone::** | **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Responsible Party (Legal and/or Financial)

First Name: | **Middle:** | **Last Name:** | **Birthdate:** / / | **Address** (if different): | **Phone:**

Employer: | **Employer Phone::** | **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other

INSURANCE INFORMATION *(PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)*

Primary Medical Insurance	Secondary Medical Insurance	Dental Insurance
Name of Insurance:	**Name of Insurance:**	**Name of Insurance:**
Policy Number:	**Policy Number:**	**Policy Number:**
Group Number:	**Group Number:**	**Group Number:**
Subscribers Name: **Birthdate:** / /	**Subscribers Name:** **Birthdate:** / /	**Subscribers Name:** **Birthdate:** / /
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Phone Number:	Alternate Phone Number:

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