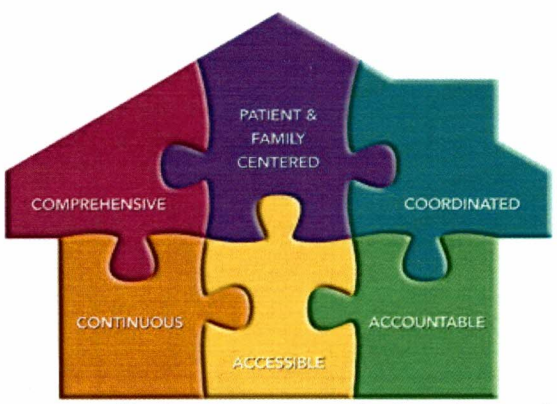
Waterfall Community Health Center

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!

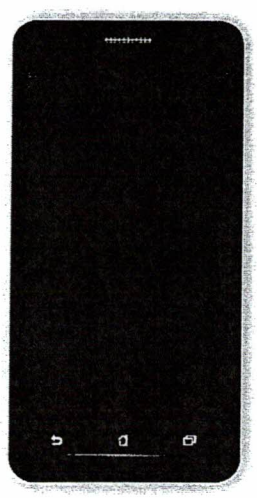


*Please note that controlled substances (stimulants, benzos, hydrocodone, oxycodone, etc) will not be prescribed at your first appointment. All medications are prescribed at the discretion of your Primary Care Provider

Waterfall
Community
Health Center

FOR YOUR CONVENIENCE

You'll receive automated courtesy text messages to remind you of upcoming appointments



If you are interested, text the word **WFall t**o **622622** and you will start receiving reminders

Waterfall
Community
Health Center

Waterfall Patient Policies

Opiate or Narcotics

Please note Opiate or Narcotic prescriptions will not be filled on your first visit with your provider. Please make sure your original provider will continue to fill your prescriptions until after you have established care with your Waterfall provider.

Please make sure to fill out and submit your records release form as this can help make the transition of moving from one provider to another easier.

No Show Policy
For New Patients:
Should you be unable to make your appointment please provide Waterfall with at least 24 hours' notice.

Failure to notify Waterfall of your inability to make your scheduled appointment will result in that appointment being documented as a "No Show"

Should you have two (2) No Shows in a one-year time frame, you will be asked and allowed to sit and wait for an opening. This will last for the reminder of the one year time.

For Established Patients:
The first No Show you will be called to determine the reason for the no show.

The second "No Show" occurrence, a letter will be sent to reinforce both policy and expectations.

Should you have three (3) No shows in a one year time frame, this may lead to termination of care at the Waterfall clinic.

Waterfall Community Health Center

OCHIN | my chart

Online access to your medical chart – anytime of the day or night

In partnership with OCHIN, who supports our clinic's electronic health record system, we are offering our patients secure, online access to their personal medical charts.

Using the OCHIN MyChart, patients can have online access to their medical information, any time of the day or night.

See what your provider sees:

- Medications, lab results, allergies, immunizations, etc.
- Access health education information
- Get your discharge instructions

Stay in touch with your provider:

- Send your provider a secure email message
- Request Refill prescriptions

Manage your appointments:

- Schedule an appointment
- See details of past or upcoming appointment

Security and Privacy:

- OCHIN MyChart is safe, secure and private
- OCHIN MyChart is password protected and sent to you using an encrypted connection that won't allow others to see your information

Getting access is easy:

- Ask your provider to turn on access for you today

Waterfall Community Health Center
Consent for Health Care Services

Agreement: Please read carefully and sign at the bottom.

Consent for Treatment:

I consent to treatment necessary for the care of the above named patient.

I authorize release of all medical records to referring health care providers and to my insurance company, if applicable. I allow fax transmittal and/or HIPAA secure electronic submission of my medical record, if necessary.

Financial Responsibility:
All insurance co-pays are due at the time of the visit. All patients with self-pay accounts are asked to bring in payment at each visit. Patents that have made payment arrangements and/or received a monthly statement must make a payment within thirty days of the statement date. If you have payment concerns, please notify the billing department. We will bill your insurance for you. However, your account remains your responsibility.

Insurance Authorization:
I understand the financial policy above and accept financial responsibility. By signing below, I assign Waterfall Community Health Center all payments due from my insurance company for services rendered.

Waterfall Community Health Center (WCHC) has a patient grievance policy that provides for a WCHC patient or authorized representative to have their complaints resolved in a prompt, reasonable and consistent manner. The policy ensures that the patient will be treated with a high quality of customer care while research and resolution are being determined.

If you cannot make your appointment, please call 24 hours in advance to cancel. We call one day prior to confirm your appointment. If you do not hear from us, please call to confirm your appointment.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. These agreements will remain in effect until revoked by me in writing. If revoked, I understand the authorization will not affect any use or disclosure of information that has already occurred.

Signature of Patient or Guardian: _____

Patient or Guardian (please print): _____

Relationship to Patient: _____

Date: _____

Waterfall Community Health Center
Consent to the Use and Disclosure of Health Information
For Treatment, Payment, and Healthcare Operations

I_____(patient name), understand that as part of my health care, Waterfall Community Health Center (WCHC) originates and maintains paper and or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.
    - I understand that WCHC is not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

You may review WCHC's **"Notice Of Privacy Practices"** for the additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT.

I understand that I have the right to revoke this CONSENT provided that I do so <u>in writing</u>, except to the extent that WCHC has already used or disclosed the information on this CONSENT.
I also understand that by refusing to sign this consent or revoking this consent, WCHC may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulation.

I further understand that WCHC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulation. A summary of the Notice will be posted in our waiting room and web site indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

I understand that as part of WCHC's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand the terms of this consent and by signing, I accept the terms. I also verify that I have received a copy or been given the opportunity to receive a copy of Waterfall Community Health Center **Notice of Privacy Practices**. I have been informed and fully understand **Rights and Responsibilities**

_____ _____
Signature of patient and or Guardian Date

For Office Use only:
( ) Consent received by_____on_____( )

Waterfall Community Health Center
Primary Care Patient Centered Medical Home Agreement

Good communication between patients, providers, and care teams is the key to better outcomes. The Waterfall staff is committed to providing you high quality care. This can be done by an understanding about our responsibilities to you and your responsibilities as a patient in our Patient Centered Medical Home.

As a patient of Waterfall Community Health Center you have the right to:

- Be treated with respect and care without judgment
- Actively participate in your health care, including decision making, treatment options and ethical decisions
- Be provided quality care that respects your values and beliefs
- Be given courteous and professional treatment
- Have your privacy, confidentiality, and dignity respected
- Be provided service in a safe, comfortable, and clean environment
- Receive materials and information about your health in a way that you understand
- Know the name and title of the providers and staff who provide your care; Choose a primary care provider
- Share concerns about your care and receive an answer in a timely manner
- Have your medical record and information about your health care treated confidentially and shared with others only as is required by law or when you have given written permission
- Understand how we charge for services and what financial help we have for medical/mental/oral health services
- **As a patient of Waterfall Community Health Center you have the responsibility to:**
- Give complete and correct information about your health history, current medical status, and changes in your symptoms and medical condition
- Participate in decision-making about your health care and to make informed decisions about treatments and procedures before they are performed
- Follow the Treatment Plan that you and your provider agree
- Inform your provider if you do not understand your Treatment Plan. If you believe you cannot follow through with the Treatment plan, please tell your provider
- Treat providers, staff, other patients, and Waterfall's property in a respectful manner
- Make and keep appointments. Please notify us within 24 hours before an appointment if you need to cancel and / or reschedule an appointment
- Be on time for scheduled appointments
- Give us your current telephone number, income and address information
- Show us your insurance card when you are seen for services
- Pay your bills
- Let us know if you have ideas for improvements. Let us know when you are pleased with your care

Powers location is open: Monday & Tuesdays from 8:00 a.m. -5:00 p.m. and Friday 9:00 a.m. to 4:00 p.m.
Marshfield location is open: Monday through Friday from 800 a.m. -5:00 p.m.
North Bend location is open:
8:00 a.m. – 7:00 p.m. Monday and Tuesday
8:00 a.m. – 5:00 p.m. Wednesday through Friday
When the office is closed, we have an after-hours nurse line available for urgent issues that cannot wait until regular office hours. Please call: 541-756-6232
By signing below, you indicate that you have read this document and that you wish to join our medical home. This is not a legally binding contract, but it is our commitment to each other in how we will work together as a Patient Centered Medical Home.

Printed Patient Name	Patient or Representative Signature	Date
Waterfall Community Health Center Representative	Signature	Date

Waterfall Community Health Center

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY/VIDEO

I consent to be photographed for receiving treatment at Waterfall Clinic.
I understand that the images from the photographs or videos may be used by my primary care provider for my treatment and/or for training and educational purposes, as the primary care provider feels appropriate. The images will not be used for any other purpose than for my care or for training and educational purposes for the clinic.
I have been offered a copy of this consent form.